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# **Exposing multiple malarias: A photo-ethnography of young people's malaria-related health practice in the Philippines.**

**Dalia Iskander**

This thesis explores malaria in the municipality of Bataraza in the Philippines. It shows how multiple versions of malaria exist inside (and in between) various bodies. These malarias are situated in both time and space, emerge interrelationally and are enacted through embodied practice. It focuses on young people in this context and shows how their identity is similarly enacted through practice. With this in mind, the thesis critically examines how photovoice, a participatory action research method can be used to both depict young people's malaria-related health practice as well as potentially alter it. During a 15-week photovoice project, 44 school-going children took photographs of their lived experience of different malarias and worked in groups to identify possible changes they might make. As a result of engaging in the photovoice process, young people's interactions with each other and their families appeared to change as well as their role in promoting health in relation to others. However, in contrast to the literature that highlights the ability of approaches like photovoice to 'empower' individuals to make changes to their lives by generating critical consciousness, this thesis makes a unique theoretical contribution by suggesting that photovoice might be effective precisely because it directly operates at and therefore interacts with the level of situated, relational and embodied practice. Taking seriously the context-specific, situated, relational and embodied nature of practice is a key message of this thesis, with important implications for behaviour change initiatives.

# Exposing multiple malarias: A photo-ethnography of young people's malaria-related health practice in the Philippines.



**Dalia Iskander**

Department of Anthropology

Durham University

2015

*Thesis submitted for the degree of Doctor of Philosophy*

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## Abbreviations

BHS	<i>Barangay</i> Health Station
BHW	<i>Barangay</i> Health Worker
CHD	Centers for Health Development
CRO	Community Relation Officer
DENR	Department of Environment and Natural Resources
df	Degrees of Freedom
DOH	Department of Health
FPIC	Free, Prior, Informed Consent
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNP	Gross National Product
GSE	The General Self-Efficacy
IEC	Information Education Campaign
IP	Indigenous peoples
IPRA	Indigenous Peoples' Rights Act
IRB	Institutional Review Board
IRS	Indoor Residual Spraying
KAP	Knowledge Attitude Practices
KLM	Kilusan Ligtas Malaria
Km	Kilometres

LGU	Local Government Unit
LLIN	Long-Lasting Insecticidal Net
LSHTM	London School of Hygiene and Tropical Medicine
MHO	Municipal Health Officer
MIS	The Malaria Indicator Survey
mm	Milimetres
MMLP	Mt. Mantalingahan Protected Landscape
NCIP	National Commission on Indigenous Peoples
NGO	Non-Governmental Organization
NMCP	National Malaria Control Programme
p	p-value
PAMB	Protected Areas Management Board
PAR	Participatory Action Research
PASu	Protected Area Superintendent
PCSD	Palawan Council for Sustainable Development
PhD	Doctor of Philosophy
PMC	Primary Health Care
PSI	Pilipinas Shell Foundation
PV	Photovoice
RDT	Rapid Diagnostic Test
RHU	Rural Health Unit
RITM	Research Institute of Tropical Medicine

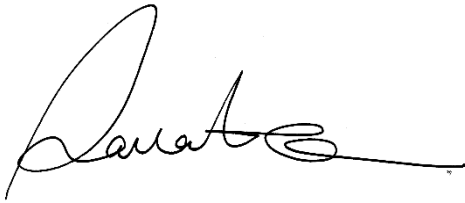
RSE	Rosenberg Self-Esteem Scale
TM/CAM	Traditional, Complementary and Alternative Medicine
USAID	United States Agency for International Development
USD	United States Dollars
WHO	World Health Organisation

## **Declaration and statement of copyright**

I declare that this thesis is my own work and that, to the best of my knowledge and belief it contains no material previously published or written by another person except where due acknowledgement has been made in the text.

The copyright of this thesis rests with the author. No quotation from it should be published without the author's prior written consent and information derived from it should be acknowledged.

**Signed**

A handwritten signature in black ink, appearing to read 'Dalia Iskander', with a long horizontal flourish extending to the right.

**Dalia Iskander**

**Date: 22.05.15**



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Above all, I would like to acknowledge all of the participants who contributed to this thesis. I am grateful to you all. In particular, I want to highlight the fact that much of the data presented here was produced and analysed by the students who took part in the photovoice aspect of this project for three months. As such, I would like to thank all of them for making this thesis possible.

## **Dedication**

*For Danilo Maceda*

## Chapter 1: Introduction

In my final tutorial for my masters in Medical Anthropology, my tutor ushered me out of her office with the words, 'go out into the world and find your question, and when you do, then do a PhD'. Out I went, and five years later, I settled on a question that I wanted to find the answer to.

By 2012, three threads of experience had woven together which helped this question to emerge. First, in February 2011, I attended a lecture by Professor Chris Whitty entitled 'Malaria' at the London School of Hygiene and Tropical Medicine, where I had been working. Malaria, he explained, is a tropical parasitic disease that is spread to humans by the bite of an infected female *Anopheles* mosquito. The burden of the disease is significant. In 2013, it caused an estimated half a million deaths, mostly among African children aged under five years old. An audience member posed a question: assuming we were successful in lessening the global transmission of malaria, what would happen when the children who were the target of so many current control interventions, grew up? How would they fare, stripped of their natural immunity and living in lower transmission settings where malaria was no longer the recipient of so much investment and effort? I was struck by the need for more research regarding older children's practices in lower transmission areas where it may not be their major health priority. Crucially, how can we engage this cohort of young people in health issues in these settings?

Second, in early 2011, I completed a project with teenagers at an inner-city school in London as part of my role as Education Mentor for the charity, Envision. In this project, students decided to use their own photographs and film-footage, taken with their mobile phones and simple point-and-shoot cameras, to create a film about drug use and abuse in their school. They used free, open-source software to create and edit their film and disseminated it through specially designed web and social media sites. The success of this project demonstrated the power of new visual technologies in engaging young people in health issues, as well as in helping them to act as agents for change. Furthermore, it highlighted how important the structured environment of schools can be in facilitating this kind of youth-led social action.

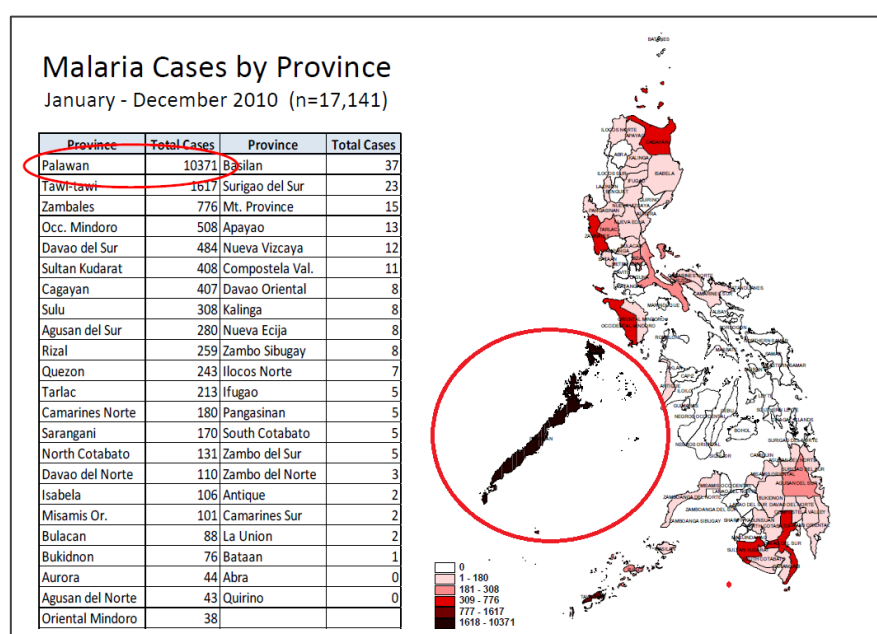
Third, in 2011, I saw an advert for a PhD studentship at the University of Durham with one supervisor (Dr Kate Hampshire) expressing an interest in projects that related to young people's health and the use of technologies. Thus, I was presented with an opportunity to refine my question, develop it into a proposal and obtain funding to do a PhD. These three experiences came together and led to this thesis in which I try to answer the question: 'What are young people's malaria-related health practices and how are these both understood, and potentially altered?' In particular, I want to examine how the intervention of one specific visual technology - photography - can help to illuminate and potentially modify young people's malaria-related health practices.

In order to answer this question, this thesis has three interrelated aims. The first is to explore what 'malaria' *is* in a particular low transmission setting. In addressing this aim, I show how and why various people enact, not one, but *multiple* malarias through their practices. The second aim is to focus on young people more specifically in order to show how and why their identity is constructed because this, in turn, has important implications for their health-related practices and the methods used to potentially alter them. The third is to explore how and why the use of a research method with photography at its heart, photovoice, can engage these young people in health and potentially alter their malaria-related health practices.

To achieve these aims, I conducted 12 months fieldwork in the municipality of Bataraza on the island of Palawan in the Philippines. I chose the Philippines because it is an example of a setting in which global efforts to control malaria have been largely successful. There has been a 75% reduction in the number of reported cases in the last decade and the country is now moving towards the goal of eliminating malaria altogether (APMEN 2012). The island province of Palawan is known to be one of the more malarious areas in the Philippines (see Figure 1.1) and the municipality of Bataraza in Southern Palawan has been identified as an area with relatively high prevalence of malaria. Bataraza is a good example of a setting where the disease is still endemic but has a fairly low transmission rate compared to other countries, such as those in sub-Saharan Africa where the global burden of malaria is highest. The setting represents a context that has, over the last decade in particular, transitioned from high to low levels of transmission due to control efforts. This makes it an appropriate case-

study in which to explore malaria-related health practice in a relatively low transmission setting.

**Figure 1.1: Malaria cases by province in Palawan, Philippines. Source (APMEN 2011).**



In Bataraza, the burden of malaria is particularly high amongst indigenous poor, rural households (DOH 2012) where infection rates have a substantial effect on child health and development (Gomes, Espino et al. 1994 cited in Espino and Manderson, 2000). Consequently, I chose to work amongst the Palawan, an ethnic group who are officially considered by the government to be the original inhabitants of Southern Palawan. In recent years, the national government has emphasised its target to enrol more Indigenous Peoples (IPs) into mainstream education in the Philippines. In Bataraza, the establishment of a number of public elementary schools in remote areas over the last decade has meant that more and more IPs are attending mainstream schools. Thus, the area is a suitable context in which to conduct a school-based participatory project with young people who have personal experience of malaria.

In terms of the school-based project itself, photovoice (PV) is a method of Participatory Action Research (PAR) that was developed in the mid-1990s by Wang and colleagues (Wang and Burris 1994; Wang and Burris 1997; Wang, Yi et al. 1998; Wang 1999). It

refers to the process in which: participants take photos that document aspects of their lives or social realities; select images to reflect on and discuss, raise emergent issues, themes and theories in group discussion; and communicate findings to the wider community and decision-makers. As well as being a useful method for a community to gather data and conduct an assessment of their needs, the ultimate aim of PV is to promote individual and social change (ibid.). Here, I conducted a PV project with predominantly ethnically Palawan school-going children in order to critically examine this technology's impact. I will describe how and why PV is effective in illuminating malaria-related practices, as well as in potentially altering them.

In this thesis, I am principally concerned with what people *do* in relation to their health. I use the term 'health practice' to describe this because it 'captures the emergent and contingent properties of people's activities in particular situations' (Cohn 2014: 157). This is in opposition to terms like health 'behaviour' which suggest there is something easily identifiable, observable and measurable that can be abstracted and removed from detailed, contextualised and situated descriptions of what people are actually doing (ibid.). Embedded in the idea of 'behaviours' is the notion that actions arise *in response* to certain stimuli or fixed phenomena; phenomena like malaria or knowledge about malaria. As discussed further below, this is implicit in much health-related research that juxtaposes structures, knowledge, beliefs and perceptions on the one hand with resultant behaviours, actions and practices on the other and suggest that the former has a straightforward and deterministic effect on the latter. These positivist approaches run the risk of constituting 'behaviour' as an '*object of observation and analysis, a representation*' (Bourdieu 1977: 2) of phenomena. As such, they ignore the instrumental role that practices might actually have in shaping the nature of phenomena themselves.

Cohn (2014) describes how the health behaviour concept is derived from health psychology and has deeply pervaded health-related studies in recent years. While its early usage referred to positive strategies that people might adopt to prevent disease, the concept has since developed more negative connotations as a plethora of more recent models and theories aim to explain individual human behaviour in order to seek ways to change it. Many early models revolve around the assumption that people do what they do as a result of rational deliberation and reasoning and give primacy to cognitive motives and intentions (ibid.: 158). For example, the 1950s saw the

development of Knowledge, Attitude, and Practice (KAP) surveys which were grounded in the idea that knowledge is a prerequisite to the intentional performance of health-related behaviours. Inherent in these studies, which are still widely used today, is an underlying assumption that there is a direct relationship between knowledge and action. Significantly, these studies suggest that by targeting interventions at changing knowledge, associated changes in behaviour will follow suit. Other psychological models developed around the same time elaborate upon additional cognitive factors that potentially affect behaviour and behaviour change and incorporate non-deliberate, non-reasoned or automatic cognitive processes. These multi-construct models (Augner & Curtis, 2007) include the Theory of Reasoned Action (Ajzen and Fishbein 1973) and the Health Belief Model (Hochbaum 1956). Central to these models is the idea that explicit knowledge and deliberate good intentions alone are not enough to affect behaviour as more implicit notions like self-esteem and self-efficacy are also important determinants of behaviour. In other words, knowledge and attitudes also affect a person's *perception* of how much *control* they have over their lives and health. These approaches are more complex than the KAP approach in that they take account of non-reasoned, non-deliberative cognitive factors and expand on the processes and mechanisms by which knowledge and attitudes influence people's perception of their own agency.

However, these models, and many other psychological theories relating to behaviour change that have been developed in more recent years, (according to Michie (2005), there are now over 30 such psychological theories) share a similar shortcoming. Essentially, they hinge on a 'linear order that conceives of various psychological determinants, potentially modified by social norms and triggered by environment cues, which then determine someone's behaviour' (Cohn 2014: 159). These approaches are also highly individualistic as behaviour is posited as an 'outcome of an individual who is presented as the obvious focus of both the processes preceding behaviour and the agent of the behaviour itself' (ibid). As a result, many health behaviour interventions are targeted at the level of individual psychology. This has manifested in a great number of studies (including those that involve photovoice) that are aimed at 'educating' and/or 'empowering' individuals to *think* differently about health issues (i.e. by altering knowledge) and/or their perceived agency in affecting their health (i.e. by increasing



levels of self-esteem and self-efficacy). However, as Cohn points out ‘a great wave of research over the last two decades attempting to develop techniques and evidence of behavioural change has proved to have surprisingly limited success’ (ibid.: 157).

In order to counter this, in this account, I try to move away from the idea of malaria-related health behaviours as a discrete category of variables that arise at an individual level in response to a single, fixed phenomenon of malaria that itself can be easily identified, observed and measured. Instead, I am concerned with describing broader health practices as they emerge *in their context* and in exploring what role these practices might actually have in shaping the nature of malaria. In doing so, I aim to incorporate the ‘social, affective, material and interrelational features of human activity’ (ibid.: 159) and give primacy to practices by showing how they, *enact*, rather than *reflect* phenomena like malaria.

Understanding the way in which malaria is practiced is at the heart of this thesis. Central to this grounding in practice is an interpretive theoretical approach. Specifically, I apply the related theoretical approaches of social constructionism and phenomenology in order to try to understand human experience and practice. Within a positivist and essentialist framework, observed evidence is considered to be the manifestation of underlying processes and structures which determine reality. Researchers who take such an approach are concerned with trying to uncover underlying ‘objective’ phenomena that regulate the social world. Within the alternative paradigm of social constructionism, reality is considered to be constantly produced through embodied lived experience and bodily practice of human actors in coordination with others (Crotty 1998). This brings various shared subjective realities into being. However, the relationship between the individual and social structure is dialectical as human actors are both ‘agentic, always actively constructing the social world’ (Burr 1995: 186) but, are also always constrained by it. Human experience and consciousness of phenomena are therefore culturally mediated. In line with this philosophical approach, phenomenology is also concerned with the active role that cultural human actors have in creating experience and consciousness but goes further by trying to understand what effect this has on the nature and shape of phenomena themselves.

In line with social constructionism, I have used predominately ethnographic research methods in order to understand the cultural context that influences cultural experience and consciousness from an 'insider' (*emic*) perspective. I have combined this with photovoice which is an example of participatory action research. This has allowed me to collect and interpret data *with* research participants permitting us to collectively gain a deeper understanding of these issues but also potentially alter them *in line* with this joint understanding. Consistent with much of anthropological enquiry, in order to gain a deeper grasp of the particular phenomenon of malaria, I have conducted my research with people who directly experience it in order to gain a richer understanding of the nature of their lived experience.

To this end, this thesis is structured in the following way:

Chapter two sets the research scene by describing exactly where it took place - Bataraza. I describe some of the characteristics of the place, as well as certain factors that have led to the 'creation' of Palawan identity. These issues are relevant to later discussions throughout the thesis related to identity, health-related practice and malaria.

In chapter three, I present a detailed account of the methods used in this mixed-methods research project, providing a critical account and justification of the various qualitative and quantitative tools that were used to generate knowledge. I also describe my experience of obtaining ethical clearance in both the UK and the Philippines. I focus on how I used each method to generate knowledge related to what people *do* but I also acknowledge that performing research of this kind, is an act in itself (Mol 2002). This acknowledgement is particularly relevant in relation to participatory action research, in which there is an explicit aim that something be *done* as a result of the research process.

The remainder of this thesis is divided into two parts. The next three chapters (four, five and six) make up Part 1 and deal with the first aim of the thesis – an exploration of what 'malaria' *is* in this low transmission setting. As mentioned above, I have approached this task by looking at how and why not one, but *multiple* malarias are enacted by different individuals in time and space. I begin this exploration in chapter four, by describing how biomedical conceptions of malaria came to the Philippines through colonial encounters and continue to feature in current 'official' health programmes. In the Philippines,

neoliberal economic policies have led to the decentralization of government. In relation to health care, this has meant that local government leaders and health professionals are tasked with implementing and delivering global malaria targets and administering financial plans. Within the context of local political structures, agendas and players, the malarias of health staff, although somewhat 'biomedical' in nature, do not represent a unified and uncritical acceptance of hegemonic discourse (Parker and Allen 2014). Instead, examining local contexts reveals that multiple 'biomedical' malarias are actively produced, reproduced and even negotiated and contested by various health professionals. Nevertheless, malarias of governance are united in some ways. For example, health professionals prioritise these malarias over other pressing health concerns that they also recognise need attention. These malarias are thought of and enacted as though they can be overcome and eventually 'eliminated' with largely technical solutions, despite the reservations that some leaders have about these goals as well as the difficulties encountered in implementing them on the ground. Furthermore, health staff push forward with education campaigns aimed at 'teaching' individuals 'correct' biomedical knowledge whilst simultaneously acknowledging the multiplicity of disease that they know exists. Following Parker and Allen (2014), I suggest that this 'dissonance' needs to be situated in the context of local political and economic factors which reveals that the prioritisation of certain discourses and enactments can help health professionals to fulfil their own strategic agendas (ibid.) within highly politicised contexts.

As leaders persevere with their own strategic agendas, they do so in relation to other groups of people in the community who also shape the nature of malarias in Bataraza. In chapter five, I turn my attention to some of the healers that are largely responsible for diagnosing and treating illnesses in the area including malaria. I show how healers, even those from the same 'systems' or 'traditions', do not necessarily share particular 'knowledge' or 'perceptions' of what malaria is, nor are they necessarily united in what they do to diagnose or treat it. Rather, like leaders, they too enact multiple kinds of malaria and practices, some shared with other healers, some not. These enacted malarias nevertheless also 'hang' (Mol 2002) together in certain ways. This is because, despite their variation, the practices of different healers are enacted alongside shared practices of professionalization. Within the field of healing, professionals distinguish

themselves in relation to their patients through the enactment of specific training and expertise as well as the use of specialised instruments. In turn, these practices mean that similar kinds of malaria are enacted that: require trained specialists to deal with them; although multiple in nature, are all objectified entities (described as ‘things’, ‘dirt’ or ‘parasites’) ‘hidden’ inside bodies that need to be ‘uncovered’ or ‘seen’; and require the use of specific instruments to both find and treat them.

These malarias exist in relation to those of patients in this setting who become afflicted with diseases. In chapter six, I explore what patients do when they fall ill. Looking at these practices reveals that, in contrast to those of healers, patients’ illnesses are not objectified entities in objectified bodies that need to be ‘uncovered’ but subjective experiences felt within their own bodies that make patients *feel sakit* (Tagalog for sick). The practices of patients are thus orientated towards their shared strategic aim of ‘feeling better’ and then maintaining these feelings of wellness as a means to prevent further illness. To do this, ‘imbalance’ in the body or the wider community needs to be restored and maintained. As a result, patients’ practices are situated within a wider set of domains than that of just the patient/healer dyadic as they incorporate much broader concepts of health, well-being and social order. The pragmatic approach that patients take to achieving and maintaining bodily and social balance and well-being means that their practices: are neither always predictable nor linear and often involve ‘straddling’ (McMillen 2004; Hampshire and Owusu 2013) multiple systems; can be characterised by features like ambivalence and fatalism which can in fact facilitate, rather than inhibit action; and are often a communal issue between families and community members that do not always require consultation with professionals.

I conclude Part 1 with a short discussion in chapter seven that summarizes some points regarding what malaria *is* in this context. In summary, this discussion highlights important issues that run contrary to some of the assumptions made in many attempts to change health behaviour as discussed above. First, instead of there being one singular and neutral malaria that exists as a solid, intangible, lone, ‘naturalised’ (Mol 2002) phenomenon, I draw on Mol’s (2002) theoretical assertion that multiple versions of the same disease (in her case atherosclerosis) exist in human bodies which are themselves multiple:

‘The body, the patient, the disease, the doctor, the technician, the technology: all of these are more than one. More than singular’

(ibid.: 5).

In line with this, I follow Mol and suggest that multiple malarias exist inside (and in between) various bodies that are *situated* in both time and space. Second, these malarias are created through practices that are not enacted by individuals in isolation but rather *in relationship* to other human actors as well as non-human objects and artefacts etc. Third, while Mol (2002) clearly demonstrates *how* various actors coordinate their practices in such a way that makes multiple versions of diseases somehow ‘hang together’ (ibid.: 55), I go further, by exploring *why* the practices of multiple actors co-ordinate and under what circumstances. To do so, I turn to Bourdieu (1977). In his *Outline of a Theory of Practice*, Bourdieu (1977) proposes that human practice is shaped and orientated by actors’ ‘internalised dispositions, schemas, and forms of know-how and competence’ (Swartz 2002: 62S) or what is referred to as *habitus*. Here, I show how malarias are not only consciously ‘known’ about, which implies that ‘behaviours’ develop in rational, deliberate response to them. Instead, I make the theoretical claim that they are enacted through the *embodied habitus* that people engage in for potentially *unconscious* strategic reasons.

Despite the multiplicity of disease, the vast majority of people in Bataraza are united by two opinions: first that malaria, however it is defined and enacted, is a problem for individual human bodies or wider communities; and second that they want to take steps to alleviate it. I suggest that in order for individual or organisational efforts to succeed, the *situated, interrelational* and *unconsciously embodied* nature of enacted malaria needs to be taken into more serious account. Accordingly, this may help malaria to be better dealt with precisely through methods that attend more to this level of *practice*.

Following this discussion of what malaria is in this setting, in Part 2, I turn my focus to young people more specifically in order to address the remaining aims of this thesis – an exploration of how and why their identity is constructed (as this has implications for their health-related practice) as well as an exploration of how and why photovoice, as a method can be used as a means of illuminating and potentially altering health-related practice. As briefly mentioned above, the vast majority of malaria control and

elimination activities are currently targeted towards children aged less than five years old due to the global prevalence of the disease amongst this age-group, particularly in high transmission settings. However, in the Philippines, where transmission has reduced, malaria remains a problem for older adolescents (defined by the World Health Organisation as young people aged between 10 and 19 years old). As malaria recedes globally, this is likely to be the case in comparable settings in the future. Although much has been learnt about the epidemiology and clinical effects of malaria in very young children, malaria in adolescence has been relatively neglected (Lalloo, Olukoya et al. 2006) and requires further attention.

As well as attending to an emerging public health need, an increased focus on the health realities of young people also pays heed to the ‘new sociology of childhood’ (Christensen and Prout 2005) that was developed in the 1990s and affords young people agency in the creation and understanding of their social and cultural worlds. Rather than being passive recipients of health care or treatment administered by adults, young people have been shown to engage directly in health practices as active health-seekers and health-promoting agents in their own right (Bush, Iannotti et al. 1985; Geissler, Nokes et al. 2000; Geissler, Meinert et al. 2001; Prince and Geissler 2001; Prince, Geissler et al. 2001; van der Geest and Geissler 2003; Christensen 2004; Onyango-Ouma, Aagaard-Hansen et al. 2005; Hameen-Anttila and Bush 2008; Hampshire, Porter et al. 2011). More significantly, the existing literature on malaria tends to explore young people’s health within a paradigm that focuses on somewhat decontextualised ‘behaviours’ (Amuge, Wabwire-Mangen et al. 2004) rather than on young people’s *practices* as they are situated within the context of their lives.

In chapter eight, I respond directly to a recent call from some medical anthropologists to start with young people’s medical realities (Hampshire, Porter et al. 2011). In this chapter, I describe what it is to grow up in the Palawan setting. I question the idea that identity is predominantly biologically given and then determines practice (including health-related practice). Instead, I explore how identity is also socially enacted. Amongst the Palawan, biological factors like chronological age, puberty and psychological development have relatively little significance in determining one’s life stage and therefore one’s health practices. Rather, young people enact a relational sense of self and what the self does through the processual act of building, maintaining and

deconstructing various kinds of relationships with others across time and space in three major social fields: the family unit, the marriage unit and school. Understanding the situated, interrelational and embodied way in which identity is enacted is significant because it has wider implications for the equally contingent health practices that young people enact in certain contexts as well as for the potential success of interventions aimed at altering practices amongst this group.

The final three chapters of this thesis (nine, ten and eleven) are dedicated to exploring how *doing* photovoice can both reveal and potentially alter young people's malaria-related health practice. I do this by providing a critical assessment of photovoice in terms of its component PAR elements: *participation*, *action* and *research*. In chapter nine, I take a deeper look at the last aspect first - photovoice as a *research* method. I provide an analysis of how the specific context in which photovoice was conducted affected both the way the project practically unfolded but also the data gathered. These contextual factors include: power and positionality; the co-facilitation process; the low-resource setting; reactions to and use of cameras; and the process of conducting participatory analysis. I provide a detailed description of the adaptations and innovations introduced in order to address some of the challenges I faced working in this particular setting. By providing ethnographic reflections on how participants and I *did* our project together, I hope to acknowledge the *situational* nature of both the lived experience of practice that was *depicted* and *altered* through photovoice as well as the anthropological knowledge generated about it.

In chapter ten, I focus on the component of *action* as I describe what photographs, as material objects, *did*. I evaluate how photovoice did, to some extent, fulfil its aim of 'catalysing personal and community change' (Wang, Yi et al. 1998). Due to the versatility of photographs, they enabled young people to create four major kinds of output that penetrated their own and their community member's lives: exhibitions; participatory films; oral presentations; and pictorial checklists and posters. In this context, photographs also brought about a number of apparent changes amongst both the participants who created them and the people they were shared with. In particular, they enabled young people to: learn new things; make friends and be together; feel less shy and more able to teach others what they had learnt; and help alter their own and their families' malaria-related health practices. Overall, photovoice seemed to change

young people's role in promoting health *in relation* to others. Photographs then, are significant, not just because of what they *mean* but also because of what they *do*. In this sense, photovoice did, in this context at least, appear to catalyse change. This chapter leads on to a discussion, in the next chapter, where I provide an explanation for *how* photovoice potentially brought about such change.

In chapter eleven, I provide an explanation for *how* photovoice facilitated this action and brought about this change by offering a critical discussion of the feature of photovoice which is regarded as the primary nexus of change in PAR - *participation*. Here, I offer a critique of the current literature on photovoice that suggests it encourages participants to participate in cognitive decision-making and therefore 'empowers' them to make changes to their lives by promoting cognitive, critical consciousness (Wang and Burris 1994; Wang and Burris 1997; Wang, Yi et al. 1998; Wang 1999). Instead, I show how photovoice requires people to participate *bodily*, not just cognitively, in both the research process and in their own health-related practices. The process of making and sharing photographs compels bodies to unconsciously participate in embodied *doing*. Building on Bourdieu's (1977) notion of '*habitus*', I argue that photovoice encourages bodily participation because it builds on what Benjamin (1993/1999) calls our 'mimetic faculty' causing participants to engage in an unconscious, but potentially transformative, process of copying, copy-making and mimetic learning. Furthermore, photovoice engages all our bodily senses, eliciting emotions including a sense of fun. The embodied nature of participating and doing means that people engage not just through their cognitive, thinking minds but also through their corporeal, feeling bodies. The emotional engagement that photovoice promotes is therefore crucial to the bodily transformation that it fosters. Bodily participation in photovoice is also potentially transformative because it is an inter-subjective process that occurs in groups, not just on an individual level. In doing so, photovoice attends to the inter-subjective and relational nature of doing by creating groups of practicing beings. By re-thinking participation in the photovoice process, I provide an alternative theoretical explanation for how it, as a method, can potentially *bodily* empower people to alter their health-related practice.

I conclude this account in a final discussion (chapter twelve) by synthesising how malaria is *done*, the idea of *bodily* empowerment and the potential impact that young



people *doing* photovoice can have on *doing* malaria differently. In opposition to many health-related studies that posit a linear relationship between 'knowing' and 'doing', and attend more to knowledge, beliefs and perceptions as a site for potential change, I subvert this and focus more on the 'doing'. This focus is both at the level at which the research lens is pointed but also the level at which change and intervention are incited. I show how a participatory method like photovoice might be effective precisely because it directly operates at and therefore interacts with the level of *situated, relational* and *embodied* practice. In doing so, I hope this thesis makes an important contribution to the theory and practice relating to 'behaviour' change initiatives.

## Chapter 2: Study site

In this chapter, I set the research scene by describing some of the features of Bataraza. In particular, I describe some of the factors that have influenced the 'creation' of Palawan identity. The contextual information presented here is relevant to later discussions throughout this thesis relating to identity, health practices and malaria.

### 2.1 Study location: Bataraza

Fieldwork was undertaken in Bataraza which is one of the 23 municipalities of Palawan. Bataraza is located at the Southeastern tip of the mainland and is bounded in the east by the Sulu Sea, in the west by a mountain range that extends from Mount Mantalingahan (the highest peak in the province) to Mount Malitub and in the southwest by the South China Sea. Bataraza is approximately 225 kilometres from the capital of Palawan, Puerto Princessa, and can be reached by road in about five to six hours. It is approximately 8.5 degrees latitude north of the equator and has a total land area of 725 kilometres<sup>2</sup>, stretching 80 kilometres in a north-easterly to south-westerly direction along the Sulu Sea (see Figure 2.1).

As in the rest of Palawan, Bataraza experiences two pronounced seasons with a monsoon between June and February and a short dry season between March and May. The annual rainfall is 1644.9 millimetres, which is much lower than the country's average.

### 2.2 Demographics and economy

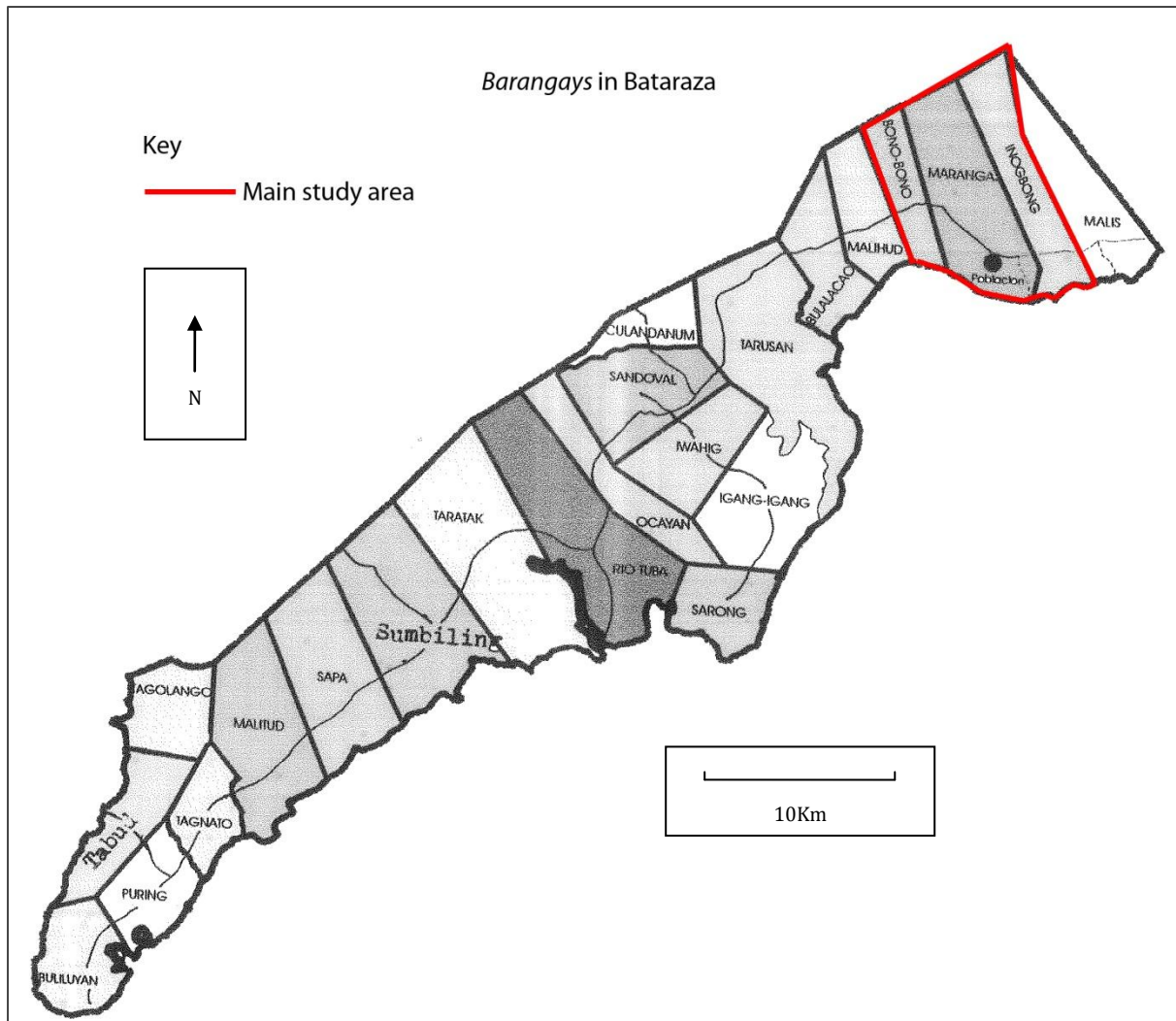
According to the 2010 census, Bataraza has a population of approximately 64,000 (PSA 2010). In the Philippines, municipalities are divided into income classes according to their average annual income during the last three calendar years. On this rating, Bataraza is ranked within the wealthiest category as a 'first-class' municipality and has an annual income of at least 55 million Philippine Pesos (approximately £800,000). Agriculture is the main source of livelihood and almost 50% of the total land area of Bataraza is agricultural. In recent years, nickel mining and processing has also become prolific with predominantly Philippine and Japanese corporations (namely the Rio Tuba Nickel Mining Corporation and Coral Bay Nickel Corporation) conducting large-scale extraction of nickel from low-grade ores.

Bataraza is subdivided into 22 *barangays*, the smallest administrative division in the Philippines. I conducted my fieldwork in many areas within Bataraza, as I interviewed and visited a wide variety of people, but my work was largely concentrated around the central town or *poblacion* and the *barangays* close to it (see Figure 2.2). I lived in Marangas, the Centre of Bataraza which is the location of the municipal government, town plaza, market and Rural Health Clinic. I conducted the photovoice project in the two *barangays* that immediately flank Marangas – Inogbong, which had a population of 3,111 in 2010 and Bonobono, which had a population of 2,673 in 2010 (PSA 2010).

**Figure 2.1: Political map of Palawan Island indicating location of Bataraza.**  
**Source: (Balingit 2012).**



**Figure 2.2: Map showing the main study site *barangays* in Bataraza.**



### 2.3 Study population: the Palawan

This study was conducted amongst predominantly Palawan communities in Bataraza. The Palawan are an ethnic group in southern Palawan that refer to themselves as “Palawan,” “Pala’wan,” or “Palawanān” depending on the dialectical variations within their native Palawano language (Dy 1991). In more recent years, the group has generally been homogenised as ‘Palawan’ by migrant settlers, a derivation borrowed from the Spanish (*ibid.*). This is now the most commonly used term to describe the group (including self-referral) and is also how I refer to them in this thesis. Although the Palawan predominantly use their native language of Palawano which is part of the Malayo-Polynesian language family (*ibid.*), a combination of the rise in migration and the increase in government education, has meant that a large number of Palawan also

use the national language of Tagalog. In this thesis, I use both Palawano and Tagalog terms in order to reflect the way in which participants refer to things.

The Palawan are officially recognised as one of the indigenous ethnic groups on the island. The government also recognise a number of other ethnic groups as being indigenous to the island including the Tagbanua and Batak who are considered indigenous to the mainland. Also considered indigenous, are groups from outlying islands who have experienced intensive and prolonged engagement with migrants since the Spanish colonial regime (1521 – 1898): the Cuyonon (native to the Cuyo Islands); the Agutaynen (native to Agutaya Island); the Cagayanen (native to Cagayancillo Island); and the Calamianen (native to islands of the Calamian group). Finally, two Muslim groups are also considered indigenous to the Palawan region: the Molbog (native to Balabac and neighbouring islands); and the ama Mapun (native to Cagayan de Tawi Tawi) (Eder 2004).

### ***2.3.1 The 'creation' of Palawan identity***

Although the Palawan are referred to as an indigenous ethnic group, it is important to note that, as with all labels, the identity of the Palawan is fluid and shifting in nature. Describing the contingent nature of identity has been a feature of much 20<sup>th</sup> century anthropology, to the extent that the knowledge that there is variation within any group, flows across boundaries and mixing 'everywhere' is an almost a 'trivial fact' (Eriksen 2007). Nevertheless, as anthropologists, it is important to continue to document the temporal and spatial contexts in which labels such as 'ethnicity' and 'indigeneity' are created and negotiated. This is particularly important in light of recent global indigenous movements where idealised portrayals of indigenous groups as stable, unchanged, traditional societies could potentially lead those who do not conform to such stereotypes losing 'credibility' in many arenas (Wawrinec 2010).

While ethnic identity is certainly very 'real' to people, sometimes coherent and stable, and has great efforts made to preserve and reproduce it, it is nevertheless fluid, contested, negotiated and shaped by historical, social, political and economic contexts as well as structural and cultural forms of power and domination. Significantly, the ethnic identities of the various groups in Palawan are constantly being produced and reproduced by a variety of structural factors: government policies, nongovernmental

(NGO) agencies and, most crucially perhaps - the peoples of the region themselves (Eder 2004). Anthropologists too, in their enthusiasm to name new 'tribes' have contributed to the construction of identity in Palawan (Eder and Fernandez 1996).

The 'indigenous movement' in post-colonial Philippines is part of a larger trend which has received global institutional support from the United Nations, the World Bank, and a host of NGOs acting across institutional levels (Theriault, 2011). In the Philippines, this has resulted in the increased official recognition of Indigenous People (IP) and their rights by post-authoritarian governments (ibid.). Specifically, the 1987 Philippine Constitution (Article II, Section 22) guarantees the recognition and promotion of the rights of IPs as a state policy. More recently, this has been extended through the Indigenous Peoples' Rights Act (IPRA) in 1997. In the same year, the National Commission on Indigenous Peoples (NCIP) was created as the implementing agency for the IPRA. Since 2008, the NCIP has been under the Department of Environment and Natural Resources (DENR) and was established in order to provide a mechanism for IPs to articulate concerns and address long-standing issues such as ancestral domain claims.

In Bataraza, the Palawan are officially considered the original indigenous inhabitants of the area, and claim indigeneity to Southern Palawan starting from the breach in the mountain range between Quezon and Abo-Abo<sup>1</sup>. However, what is constituted as 'Palawan' is contested, even within the group itself. As my translator explained:

'Before the NCIP, those [ethnic groups] considered themselves [to be] indigenous but not just those - there are even more groups who considered themselves [to be] but they were discounted [by the NCIP]. Like the Kaney - they are like the Palawan and they live in the trees and are experts in using blow guns. Another group is the Tau't Batù. They live in the rocks in the mountains but they are not recognised either. The NCIP decided that all of them are just one - the Palawan. But they all speak different languages. The people they don't have a voice. They cannot express their views. But the people are not happy about that'

Despite this contestation, together with other groups recognised as being indigenous to the island, the Palawan are commonly referred to (including self-referral) as 'natives' or

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<sup>1</sup> The Tagbanua claim and are recognised as being indigenous to the central southern part of Palawan.

*katutubo* (literally translates as ‘innate’ in Tagalog) and ‘highlanders’, and are defined in contrast to ‘non-indigenous’, ‘migrants’ and ‘lowlanders’. In Southern Palawan, the latter refers to other ethnic groups who have settled either permanently or temporarily on this frontier land. Muslim Taosug traders from the Sulu Archipelago have a long history of settlement on the seacoast and coastal plains of South Palawan stretching back to the late 1700s which pushed many Palawan in and upland in an attempt to distance themselves from these migrant groups (Eder and Fernandez 1996). Historically, Palawan island was sparsely populated due to its endemic malaria and historical function as the site of a leper and penal colony (Lacuna-Richman 2006). However, in the early 20<sup>th</sup> century, the island became an attractive ‘frontier’ for thousands of migrants from other parts of the Philippines (ibid.) and the large-scale displacement of the Palawan and resettlement into the upland mountainous interior started to take place. Government resettling programmes following World War 2 brought thousands more migrants into Palawan from areas such as the Visayas. In recent years the population has also increased further still from people fleeing violence-prone islands such as Luzon and Mindanao (Eder and Fernandez 1996; Eder 2004).

However, the uplander-lowlander dichotomy that corresponds with that of indigenous-non-indigenous, has a longer history which makes it less clear-cut. Specifically, the uplander-lowlander characterisation that remains today was defined throughout the Philippines during the Spanish (1521–1898) and American (1898–1946) colonial periods and is representative of colonial attempts to simplify complex societies into ‘uplander’ and ‘lowlander’ peoples according to factors like ethnicity, agricultural practices and elevation (Zialcita 2005 cited in Dressler and Turner, 2007). Additionally, despite the heterogeneity of ethnicity and religion amongst settlers, the ‘lowlanders’ are referred to collectively as ‘Christians’. Again, this seems to be a hangover from the Spanish colonial era when, as Dressler and Turner (2007) explain:

‘Only as the Spaniards first began proselytization campaigns among lowland peoples, and then faced difficulty converting others who upheld their own custom by living in or retreating to the uplands, did divisions between Christian lowlander and ‘tribal’ uplander become apparent’

(ibid.: 1452)

Consequently, the Palawan should not be seen as an isolated bounded community. On the contrary, many, especially those living in the areas where I worked, have had a long history of contact with other ethnic groups within the Philippines (both with those defined now as indigenous and non-indigenous) as well as with those from outside including 'western' culture. Inter-marriage with migrants is increasingly common amongst the Palawan and many different cultural practices have been assimilated or adopted as described throughout this chapter. This history of interrelatedness is evident in the increasing heterogeneity of livelihood practices, social and political organisation and religious practices as described below. In this way, the indigeneity ascribed and claimed by the Palawan has 'less to do with blood ties and length of residence and more to do with the group's past and present social position *vis-a-vis* civil society and the state' (Dressler and Turner 2007: 1453).

### **2.3.2 Subsistence and economy**

Concepts of Palawan identity have been closely associated with subsistence methods. However, this is neither homogenous nor static. In the past, the Palawan largely relied on a mixture of food gathering, hunting using blowguns and fishing on the one hand, and a rotational cycle of slash and burn agriculture on the other – swidden *kaingin* (Dressler 2005). Rice is by far the most valuable food crop for the Palawan but other root crops like cassava also play a significant role in subsistence (Macdonald 2007). Swidden farming has a contentious place in Philippine history as, along with widespread logging that began in the Spanish period, it is believed by many, to be responsible for large-scale forest destruction throughout the archipelago (Suarez and Sajise 2010) as well as general environmental degradation (Novellino 2000). Postcolonial discourses continue to dominate conservation narratives and pit destructive, illegitimate indigenous livelihood techniques against 'productive' lowland techniques for growing irrigated rice. As Dressler (2005) explains:

‘The Philippine state continues to sustain a colonial legacy of criminalizing swidden based on the dominant discourse of it being irrational and unproductive agriculture’.

(ibid.: 21)



In reality, many scholars have shown that these taken for granted 'truths' obscure the relative productivity of shifting cultivation (Leach and Mearns 1996 in Dressler, 2005). In any case, the Palawan, like the Tagbanua, view swidden and their ancestral lands as not only necessarily for their subsistence, but also integral to their religion, livelihoods and lifeways (Dressler 2005). A lot has been written regarding land use and livelihood in Palawan and the impact on indigenous groups like the Palawan (Eder and Fernandez 1996; Eder 1997; Eder 2004; Dressler 2005; Dressler and Turner 2007) but suffice to say that the increasing vilification of swidden cultivation, intense conservation agendas, land regulation of primary forest coupled with increased migration into the island have meant that in reality, the Palawan are losing control of their ancestral lands and as such are no longer restricted to just *kaingin* subsistence methods. Rather, many increasingly engage in a mixed economy which is very much interrelated with 'lowland' techniques. Many Palawan I spoke to retained their swidden *kaingin* but also engaged in daily *arawan* (Tagalog for cash labour) on migrant 'lowland fields'. This was largely due to land pressures and conservation restrictions which means people are not able to open up new areas of the forest for cultivation. However, many people also feel that lowland techniques are 'easier' than traditional swidden cultivation, presenting them with a less labour intensive way to earn money. Some Palawan, especially those living in lowland areas, have in recent years, gone so far as to adopt 'lowland' livelihood techniques and plant irrigated rice or coconut plantation themselves. In short, by necessity of survival, IPs are increasingly being integrated into the wider market economy in the whole country (Carino 2007).

In postcolonial Palawan, constructs that define those who are 'indigenous' and those who are not have been particularly propagated through state conservation agendas which have supported even stronger articulations of difference (Dressler and Turner 2007) that heavily revolve around land use and cultivation. The Mt. Mantalingahan Protected Landscape (MMPL) is a mountain range covering 120,457 hectares in Southern Palawan, Philippines. MMPL was declared a protected area in June 2009 through Presidential Proclamation 1815, and is within the territorial jurisdiction of municipalities including Bataraza. It is currently the largest terrestrial protected area in Palawan. As such, under the mandate of the Philippine state, national park land is zoned and swidden agriculture banned in 'old' growth forest (Dressler 2005).

At a national level, the Department of Environment and Natural Resources (DENR) is the lead institution responsible for protected areas in Philippines and at regional level, the Palawan Council for Sustainable Development (PCSD) oversees the use of natural resources in Palawan. At a more local level, a Protected Areas Management Board (PAMB) and Protected Area Superintendent (PASu) are responsible for local land use issues within the MMLP (Matias 2012). The National Commission for Indigenous People (NCIP) is the institution responsible for determining and defining the 'boundaries of ancestral domains and ancestral lands' (NCIP 2012-13). As such, the NCIP is mandated to accept, process and approve all applications from IPs involving ancestral land/domains claims in the Province of Palawan (ibid.). In Bataraza, both the NCIP and MMPL are notoriously bureaucratic and seen by many people that I spoke to, to be unresponsive and detrimental to their needs.

It is against this backdrop that concepts of ethnicity and, in particular, indigeneity are (re)defined both for and by the Palawan. Indigeneity in particular is institutionalised by government policies, both national and regional as well as on a more local level by a number of government, NGO and advocacy groups who are also involved with land use and conservation. Within this context, indigenous swidden cultivators are pitted against migrant paddy rice farmers. The result is that a number of institutions, whether explicitly or not, impose their conceptual frameworks, economic interests, and (anti-) political (Ferguson 1990) agendas on the very people whose interests they claim to promote.

### ***2.3.3 Social and political organisation***

Palawan settlements are based on *rurungan* (Palawano for neighbourhoods) or *sang keperurungan* (one unit of neighbourhood). While these units have no clear visual, territorial or administrative bounds, in line with Macdonald's (2007) analysis, these do appear to be genuine social units:

'based on pre-existing social ties activated in such a way as to create a social structure, thus allowing closer relationships between its members, frequent interaction, and a sense of community . . it is a genuine social unit, and one with clearly recognized rules of membership.'

(ibid.: 24)

In terms of group membership, the core of a settlement consists of clusters of inter-related households which are based on the rule of uxorilocality (ibid.). When a couple marry, the husband will typically move to live in the wife's place of residence, or as close as possible to the wife's parents or nearest kinsman with the status of elder (ibid.). In this way, through marriage, men adhere to a social organisation based on groups of sisters (Dy 1991). As such, settlements consist of 'small nuclei of kinsman and in-laws, typically several households of married sisters living near to their father's household' (Macdonald 2007: 25). Several of these groups in turn, cluster together into settlement groups through kinship ties between siblings and relatives, usually at the parental level. Settlements are led by one *panglima* (Palawano for leader) who is customarily the oldest male sibling, as described below. People colloquially refer to Palawan social organisation as a 'mushroom' type of formation.

'Blood bonds' are important to the Palawan and tie family groups together but it is important to note that distant relatives and even close friends can also be considered blood relatives similar to other 'cultures of relatedness' (Carsten 2000). As Macdonald (2007) explains, kin relationships (as well as sex and relative age) are important in forming the basis for one's role and status in society as well as one's appropriate behaviour towards other people (ibid.). The Palawan are a largely egalitarian group in that, beyond the *panglima*, there is an absence of any kind of formal hierarchy (no title, rank, class or caste) and descent is bilateral through both matrilineal and patrilineal lines (Dy 1991). Groups are therefore not automatically created at birth and instead 'a great number of possible affiliations' (ibid.: 62) are made possible in life. Despite there being no long-term organising principal that persists through generations, local settlements and kin groups do remain stable over the years as in this context, kin acts more as means to establish reciprocal roles rather than to recruit members to the group (ibid.: 72).

In terms of these reciprocal social roles, there is a certain amount of asymmetry in Palawan social organisation. Although women, namely sisters, cement the community together through marriage and descent is cognatic, it is men who wield authority and in-marrying men are said to *pikit* (Palawano for stick) to their high status, wife-giving, fathers-in-law due to the rule matrilineal residence (uxorilocality).

Within groups, the customs of *adat pagbagi* (Palawano for sharing) and *tabang* (Palawano for mutual help) between sisters, husband and wife, elder and younger (Dy 1991: 184) are crucial to the maintenance of social relations. Within a household 'general reciprocity and sharing is the rule (Macdonald 2007: 53):

'Within the local group (*rurungan*) the redistribution model is dominant, pooling at the centre and then redistributing resources. There is however, a major difference between the way the agricultural product (paddy, root crops, vegetables) is allocated between members of the group and the way game – and to a certain extent other wild products like honey or fishes – are redistributed in the same group. Essentially, swiddens were privately cultivated and their product privately owned by each household. However, I observed that sisters, who are the main agents in gathering these products, would tend to share their crops, visiting each other's fields together, gathering the products together, and partitioning them among themselves. In this way, through an exchange between siblings, the main dietary items, namely root crops and other vegetables, would circulate between household. Rice, on the other hand, the most prized item, was stored and not automatically redistributed but could be exchanged or sold'

(ibid.: 53-54)

In terms of social and political organisation, the Palawan structure described above is in a state of flux due to re-organisation being imposed by government agencies, principally the NCIP, who ironically are mandated to protect and preserve indigenous ways of life. Traditionally, Palawan settlements fall under the leadership of a *panglima* who is the oldest father or uncle of a group of sisters and first cousins considered sisters (Dy 1991). It is the *panglima* who specialises in *adat* (Palawano for customary law) and is a master of *bitsara* (Palawano for debating) which is a crucial skill for many social interactions. The position of *panglima* is a lifelong one and is inherited through royal 'bloodline'. Despite this organisation dating back to what people refer to as 'time immemorial', the NCIP are in a process of restructuring all indigenous people of Palawan into one homogenous arrangement that no longer reflects the particularity of the Palawan. As my translator explained:

‘Now the NCIP wants to get rid of the *panglimas* the way they are now and put in their place ‘Chieftains’. Each Chieftain must have 40-50 families under them. So, if I am a *panglima* with a royal bloodline and 40-50 families under me then I am eligible to become a Chieftain but if I am a *panglima* with a bloodline and only 30 families under me then I cannot become a Chieftain by the NCIP’

NCIP Chieftains are now also obligated to appoint a tribal council and fill positions. Although this structure is traditional to some other indigenous groups, namely the Tagbanua, who have distinct cultural customs and traditions acquired from the people of Sulu and Borneo (Reynaldo 1994), it has no salience for the Palawan (as well as other IP groups on Palawan island). At the time of fieldwork, the NCIP was still in the process of installing new Chieftains in Bataraza which created a confusing mosaic of authority. In some areas, new Chieftains had been installed and validated by the NCIP and old *panglimas* effectively lost their inherited status. In others, the process of ‘validation’ was still on-going whereby the NCIP were in the process of verifying that *panglima*’s bloodline claims were legitimate before selecting a Chieftain from possible candidates. The validation of *panglimas* is complicated. Although the title is usually passed onto oldest male sons, this is by no means automatic and sons will have to prove that they have personal qualities fitting the role including ‘dignity and honour’. In some cases, when there is no suitable heir, or the heir is too young, the community may choose a leader from outside the direct bloodline who ‘borrows’ the position of *panglima*. The NCIP’s requirement for *panglimas* to prove their legitimate ancestry has therefore caused problems for some *panglimas* who, rather than inheriting the position directly from their ancestors, have ‘borrowed’ the position, sometimes over many previous generations.

The reorganisation of the social fabric of the Palawan is currently causing a lot of local level tension and power struggles between *panglimas* and Chieftains competing over allegiance from households and jurisdiction of the same areas. Members of the community are also divided in terms of their loyalty. In some cases, their traditional leader whom they recognise as legitimate, has been replaced by a newly imposed Chieftain who neither has the right by tradition nor by election to govern them. As an outsider wanting to conduct research within villages, the uncertain political

organisation of communities also caused me many dilemmas. In areas where there was an NCIP Chieftain, it was easier to assess who I should approach to obtain 'official' permission to conduct research. However, my translator often advised me to also seek approval from other *panglimas*, who although no longer 'official', still held much sway in communities. However, where there was no 'validated' Chieftain, or where bloodlines and legitimacy was still being contested, the chain of command was far less visible.

The reorganisation of the Palawan by the NCIP is a highly contentious issue in Bataraza as elsewhere in Palawan. Many Palawan, particularly older members, feel that the NCIP have disregarded and circumvented local decision-making processes for their own gain and they certainly had a reputation for corruption with a number of law suits currently being threatened or issued against them (Aning 2011). In particular, I heard many stories that linked NCIP activities to mining companies – something that has substantially been reported in the local press and been the focus of many advocacy campaigns by local NGOs. For example, the Philippine Daily Inquirer reported that the NCIP and MacroAsia Corp had used 'fake' tribal leaders to support the approval of mining operations in protected tribal lands. According to the article, none of the 30 so-called tribal leaders lived in their ancestral domain and 15 did not even belong to the Palawan ethnic group (Balana 2011). These allegations were typical of stories I heard and in general, I was warned by many people, even those in local government positions, to avoid any dealings with the NCIP.

In many ways, the NCIP has failed to meet the expectations of the indigenous peoples (AITPN 2008) and it is perhaps too early to tell exactly what the ramifications of the current reorganisation of leadership will be. Again however, as with livelihood, it would be a mistake to see the political and social organisation of the Palawan as bounded, stable and internally homogeneous.

#### **2.3.4 Palawan spiritual world**

As Macdonald (2007) articulates, the use of the word 'religion' to describe this aspect of Palawan culture is misleading as the Palawan do not have a religion in the sense of 'organised religions with their fixed codes of ethics, theodicy, and eschatology, not to mention a clergy structured like a bureaucracy' (ibid.: 91). Rather, Palawan spiritual life consists of beliefs and customs that are handed down from the ancestors and merge

with ‘all sorts of habits and notions that, in the Western sense, have no religious meaning’ (ibid.). Some of the main features of the spiritual life of the Palawan are discussed in more detail below as they are significant to health and health practices. It is important to note here, that despite the heterogeneity of beliefs and practices evident in ‘religious’ life, there is still a distinction to be made between these beliefs and practices and those that align with world religions, namely Christianity and Islam, which are also widespread in Bataraza. While some Palawan may have converted to one of these more formal religions, they, by nature of being so distinct from traditional beliefs, exist in their own kind of ‘ideological niche’ (Macdonald 2007: 96) and by no means exclude the persistence of traditional beliefs and practices which are so fundamental to life and intricately woven into Palawan ways of being.

#### ***2.3.4.1 Palawan spiritual life – Ampu, diwata and the tandayag***

In the Palawan conception, there is one overarching Supreme Being – *Ampu* (Palawano) who is often referred to as ‘Lord’ or ‘God’, terms borrowed from Christianity. *Ampu* created everything and is sometimes described as a ‘weaver’. As well as *Ampu*, other *diwata* (Palawano for spirit like entities) also exist who are described as *taqaw* (Palawano for human beings), but are essentially different from *tawbanar* (Palawano for ‘real’ people) in that they are ‘unseen’. *Diwata* are associated with natural entities like the mountains, rocks, trees, forests, rivers, seas and the sky as well as with animals and plants. *Diwata* are said to own and inhabit these entities. While these spirits can theoretically be good or bad, all have the potential to become angered or irate by human action. In this case, spirits will cause humans to suffer illness and misfortune through *bati* (from *nabati* in Tagalog meaning to be greeted), or *salibegbeg/samban* (Palawano) which roughly translates as ‘greetings’ from the spirits. This is caused by human beings passing by, disturbing, ignoring or harming *diwata* in some way which results in them greeting or speaking the name of the victim. *Bati* is a very common cause of illness for the Palawan and many people I spoke to had suffered from it. Although the symptoms varied between participants, they commonly included fever, sweating, body pain, rashes, insomnia and the body becoming ‘stiff’ or ‘too strong’ to move. While spirits are the cause of a lot of illness and misfortune, there is potential to assuage and appease them as discussed in chapters 5 and 6. As well as malevolent forces, good spirits can also protect human beings.

As well as *Ampu* and *diwata*, a range of other beings also exist that can cause disease, misfortune and death including dwarves, giants and other animal-like creatures. One such *tandayag* (Palawano for large fish-like monster) resides in the centre of the world and when angered, can rise up through the sea bringing about months of drought or heavy rain to thwart farming. It even has the potential to swallow up the whole land. The *tandayag* is sent as a curse from *Ampu* as a result of prohibited behaviours most notably *sambung* (Palawano for incest) between siblings, parents or first cousins.

The landscape that the Palawan inhabit is therefore very much ‘alive’ with entities that vastly outnumber living humans. Every-day life for the Palawan is therefore influenced by these entities as they govern practice and affect the way in which people interact with the space in which they live in their attempts to avoid illness, misfortune and death as well as curry favour through prayer, offerings and ceremonies.

#### **2.3.4.2 The components of a person**

As Macdonald explains, the Palawan conceive of the person as being made of five constituent parts that interconnect to make a whole:

‘1) the *kurudwa* (souls); 2) the *ginawa* (breath, life); 3) the *nakem* (awareness, conscious, mind); and 4) the *atej* (liver, seat of some of the main emotions of the “heart” in the moral sense of the world, the place whence love, generosity, anger, and so on, originate). There is also the physical body (*bilug*), with all its functions’

(ibid.: 124)

Of particular interest in terms of illness are the *ginawa* and the *kurudwa*. *Ginawa* is an innate vital force, responsible for corporeal existence that stays within the body (Tan 2008) and connects people to an invisible universe (Macdonald 2007). This life force is both a source of health as well as potential source of illness (as it can be manipulated through witchcraft). It is not just limited to human beings but is also present in other animate entities like plants and animals (whose potency have the power to heal and harm) as well as inanimate objects like healing charms which, as discussed in chapter 5, can repel and cure illness (Tan 2008).

Conversely, *kurudwa* is conceived of more as a companion that has the ability to detach from the body and even exist materially both spatially and temporally beyond the life of



the body of a person as a ghost. It is the detachable quality of the *kurudwa* that causes people to become sick as it can be dislodged or lost, for example as a result of a fall. The soul's wandering quality means it also has the *compulsion* to wander off, mostly at night, in dreams. This impulsiveness can have fatal consequences if the *kurdawa* were to encounter a dark force. However, less harmfully, it is also this quality of the soul that allows people to dream (Macdonald 2007) and for healers to have visualisations in which their own *kurudwa* leaves their body to seek out lost *kurudwa* or talk with *diwata* (spirits) who can help in the healing process. The *kurudwa* is linked to the *nakem* (mind) as the seat of 'understanding and awareness' (Tan 2008) but not feelings and emotion which are restricted to the *atej* (liver) (Macdonald 2007). Consequently, soul-loss, visualisations and dreams come with a sense of unawareness or what some people who are suffering illness caused by soul-loss describe as being 'out of their mind' or 'unaware of their surroundings'.

Similar to many groups in the Philippines and more generally in Southeast Asia, there is not just one, but multiple *kurudwa* in the body. People are thought to be born 'complete' with souls but they are less securely attached in children who are consequently more prone to illnesses caused by soul wandering or detachment. Death can be caused by and is characterised by a permanent loss of *kurudwa*. I found that the number and location of souls differed between participants. However, all participants located one soul in their head that was somehow different and superior to other souls. As one informant explains:

'There are 4 souls – one in the feet, hands, ears and head. [After death], the [souls in the] feet, hands and ears remain here on earth and can become *bangun* [Palawano for ghost] but the soul in the head goes to *Ampu* [Palawano for 'God']. Souls are not necessarily bad, they can be friendly, but the ones from the feet, hands and ears *are* bad. The one from the head can be a good one though. . . The soul from the head is the only soul that is *matampohin* [Tagalog for sensitive] and can be easily offended. The result is that it can be removed from the body, even when you are still alive'

As a result of this sensitivity of the head's *kurudwa*, people do not walk or sit near to the head, especially when someone is sleeping so as not to dislodge the soul and potentially bring about illness.

As described above, death for the Palawan is characterised by a permanent loss of *kurudwa* from the body. All of the *kurudwa* hover over the head of the deceased until a specialist healer ritually separates (cuts) the souls from the living. Relatives and neighbours will then wrap the body in rattan or cloth and construct a *garamba* (Palawano for bamboo stretcher) to carry the body to be buried in a deep hole. The hole is often lined with bamboo flooring and sometimes covered with leaves or grass. In terms of the afterlife, and resonant with Christian cosmology, participants told me that a messenger of *Ampu* is responsible for guiding souls to *Ampu* be judged. People told me of a place called *langit*, created by *Ampu* where all the souls of those of who were judged to be 'good' are eligible to live after death. It is often described as a beautiful house belonging to *Ampu*. This is in contrast to the burning fires where 'bad' souls are condemned to reside – *narka*. Conceptions of life after death varied amongst participants but converged around the idea that after death, specific places are allocated to the *kurudwa* of different kinds of people: the Christians or 'lowlanders'; the Muslims; the 'Americans' (general term of foreigners); and the Palawan. In all conceptions, the place reserved for the Palawan is the most beautiful, characterised by abundant light and rice and located furthest away from the burning fires. After judgement, all of the *kurudwa* of the deceased can technically return back to earth as ghosts and are led back by hawk-like birds. However, some people reported that the soul in the head stays with *Ampu* in his house and only the other souls return to earth. These souls can appear to their friends and relatives in the form of ghosts or dreams and are also a possible source of illness if offended, angered or forgotten. On the other hand, they can be appealed to intercede between humans and *Ampu* and therefore can also be a source of protection.

## **2.4 Conclusion**

In this chapter, I have described some of the characteristics of the field site of Bataraza. In particular, I have discussed certain factors regarding the identity of the study population. Although the Palawan are referred to as an indigenous ethnic group, it is important to note that, as with all labels, the Palawan are neither homogenous, absolute nor fixed temporally or spatially and it would be misleading to lump a whole ethnic

group to a broad territory (Benjamin 2002 cited in Wawrinec, 2010) under the marker of 'indigeneity'. As discussed throughout this thesis, this is particularly significant in the area of health where there has been a tendency to pit 'indigenous' or 'traditional' knowledge and practices against that which are considered 'biomedical' or 'modern' and suggest that these terms reflect internally coherent 'systems' with clear boundaries (Last 1981) that align with identity categories. Here, I have demonstrated how common markers of identity like livelihood, political and social organisation and spiritual life are far from bounded, stable and internally homogeneous. In reality, 'indigeneity' and any knowledge and practices associated with it, are fluid, contingent and shifting in nature.

## Chapter 3: Methods

In this chapter, I outline the methods used in this study and provide a justification for the decisions made in the research design, fieldwork and post-fieldwork analysis. I adopted a mixed-method approach and used a range of qualitative and quantitative tools to generate knowledge about practices. In this chapter, I provide an outline of the main methods but a much more detailed account of photovoice is given in chapter 9. The major challenge of mixed-methods research is to combine methods that are based on different paradigms and therefore different views of reality. While this requires a pragmatic approach, the ultimate aim should be to maintain the integrity of methods and their epistemological and ontological roots in order to best achieve truly complementary data that reflect different interpretations of phenomena and the world (Bryman 2001). Here, I focus on how I used methods in order to generate different kinds of knowledge about malaria-related health practice.

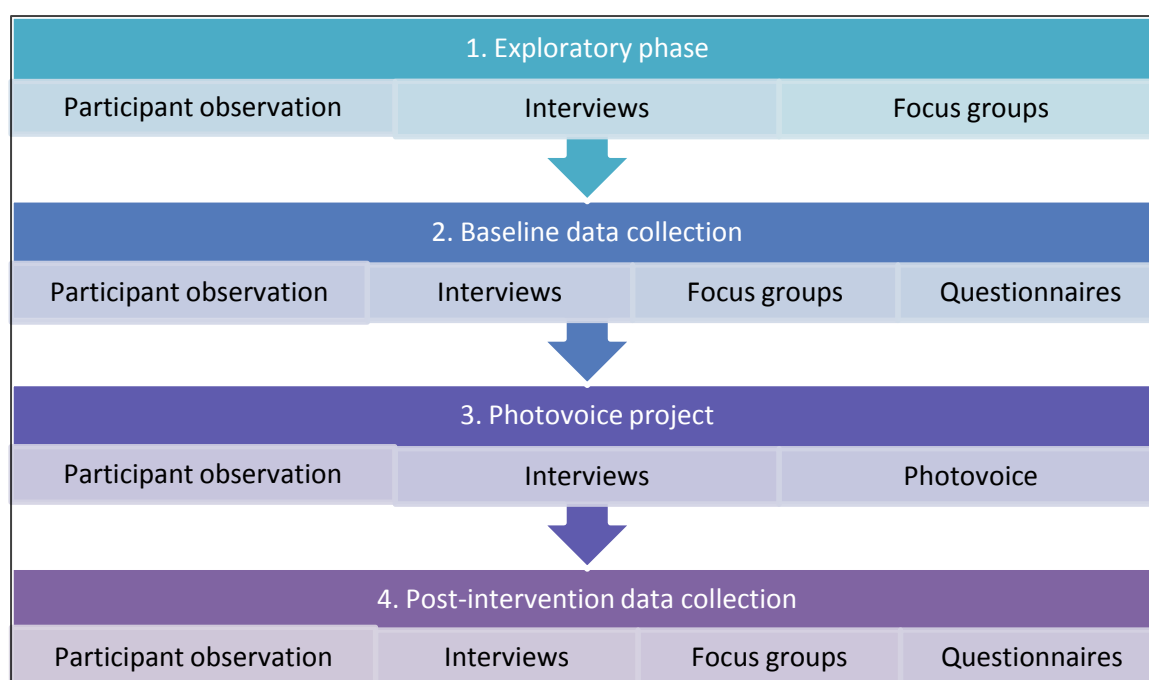
### **3.1 Study design: a mixed-methods approach**

In this thesis, I have employed a number of methods in the field. The term 'triangulation' traditionally refers to the mixing of different types of method to 'strengthen the validity of inquiry results' (Greene, Caracelli et al. 1989 cited in Walden et al., 1999). However, the term 'mixed-method' has been applied to a methodology using at least one qualitative and one quantitative method to 'reveal different aspects' but not to necessarily seek convergence or validation of results (Walden, Mwangulube et al. 1999). In line with this, I have adopted a mixed-methods approach.

### **3.2 Fieldwork**

I made an initial scoping visit to southern Palawan in April 2012 in order to select a field site and make contact with institutions and individuals who could help me conduct fieldwork. Fieldwork 'proper' was conducted over 12 months between August 2012 and February 2014 in the municipality of Bataraza. The project consisted of four distinct phases as outlined in Figure 3.1.

**Figure 3.1 Figure illustrating project phases.**



### 3.3 Research team

In line with the reflexive turn in anthropology (Clifford and Marcus 1986), it is important to continually re-emphasise the inter-subjective nature of fieldwork. Knowledge that is created in the field is a product of many inter-subjective relationships not just between researchers and participants but also between researchers and colleagues, partners and gatekeepers. This fact is sometimes obscured in anthropological writing and discourse which fails to acknowledge the processes by which knowledge is co-produced (Fabian 1983).

The knowledge that is presented in this thesis was generated in coordination with a number of people who were instrumental to the project. I partnered with colleagues from the Research Institute of Tropical Medicine (RITM) in Manila and the Rural Health Unit in Bataraza who first introduced me to the area of Bataraza, helped me gain access to communities and provided logistical and practical support throughout.

In addition, I relied heavily on my translator (and his wife), who not only translated for me but acted as my principal gatekeeper due to his extensive experience working with the Palawan. My translator moved to Bataraza in 2004 as pastor of a small Pentecostal church belonging to the Assemblies of God Fellowship. The congregation of this church are largely made up of Palawan members. Initially, and perhaps naturally, the

participants that he introduced me to were from his congregation (i.e. ethnic Palawans who had converted to Christianity). However, as time went on, he was also able to introduce me to many other individuals and communities including areas where large numbers of Palawan had converted to Islam or had retained 'traditional' beliefs. In part, this was at my request to 'broaden' the kinds of people we met but was also facilitated by the direction given by local health staff regarding communities to work in based on numbers of malaria cases. This did not present a problem to my translator and he was instrumental in securing my access to these areas. As well as being a pastor, both he and his wife work as community teachers through the Alternative Learning System and my translator's wife is a *Barangay* Health Worker. As such, they worked in a wide variety of areas and were well-known and trusted by many members of the community for a host of reasons beyond their association with the church.

As I was living in a pharmacy and working in close association with the Rural Health Unit, it was important for me to gain access to 'traditional' healers from the Palawan community. In this too, my translator's position, as well as that of his wife, was instrumental. Both were from a bloodline of *babalyans* (Tagbanua for shamans) and therefore possessed a lot of knowledge relating to Palawan healing practices (as there are many similarities). Furthermore, they were known and respected by many healers and able to build instant rapport with them on this basis. In addition, due to his familiarity with local communities and his fluency in Tagalog and English as well as proficiency in dialects like Tagbanwa, Palawano and Ilocano, my translator had also translated for three or four other foreign researchers, mainly anthropologists and was very aware of anthropological research approaches, theories and methods. As such, both my translator and his wife were very well placed to act as gatekeepers for me. The couple usually both accompanied me on outings, conducted the vast majority of my translation, administered the questionnaires and acted as the main co-facilitators in the photovoice project.

As photovoice was used here as a participatory action research method, the teachers and pupils that took part in the sessions, were also instrumental in that they acted as research assistants in this aspect of the study. It was they who essentially collected and analysed the vast amounts of visual and narrative data that lies at the heart of this

thesis. This co-production of knowledge was central to the whole endeavour of the project.

### **3.4 Qualitative data collection tools**

#### **3.4.1 Participant observation**

As Bueger (2014), explains, the core elements of practice are ‘implicit knowledge, bodily movements and artefacts’ (ibid.: 388). In order to best capture these elements in relation to health, I used predominantly ethnographic research methods. Ethnographic fieldwork is often cited as the main distinguishing feature of anthropology. Observation, in turn, is the hallmark of ethnography. Classically, fieldwork entails total immersion of the researcher in the field setting 24 hours a day, seven days a week for usually at least one year’ (Whitehead 2005). ‘In this way the ethnographer not only becomes familiar with the spatial dimensions of the research setting, and its socio-cultural dynamics, but also how those dynamics may change at certain times of the day, week or year’ (ibid.: 3). In order to attend to practices, engaging in ethnography was vital throughout all phases of research as it allowed me to directly observe the ‘activities, events, buildings, instruments, procedures, and so on’ (Mol 2002: 32) that are crucial to how practice is enacted through space and time.

Ethnographic observers make observations in the field that can take the form of either non-participant or participant. In reality, most ethnographers will take on both roles in the lifetime of their research and the distinction between the two forms is not so clear-cut. Non-participant observation entails standing back, watching and passively recording while participant observation refers to a methodology where the ethnographer immerses themselves in the context that they are observing and takes on an active role. In reality, the extent to which researchers are ever fully able to immerse themselves in the lives of their participants is debatable and reflects a common discomfiture amongst researchers with the gap between the actual experience of conducting fieldwork and the archetypal view of how it ‘should be’ (Gupta and Ferguson 1997) done.

I lived in a pharmacy located in the *poblacion* (town centre) of Bataraza which was very close to the Rural Health Unit (RHU) and, as such, gained an invaluable insight into the ‘formal’ health care sector. I spent a lot of time in the pharmacy observing

patient/provider practices, particularly relating to how malaria was diagnosed and treated and the artefacts involved in this. I also spent a lot of time in the RHU and assisted health staff in the practices that they conducted on medical missions like screening for malaria, distributing bed-nets and disseminating public health information. I accompanied *Barangay* Health Workers and Rapid Diagnostic Test technicians on their rounds in the community and, as such, was able to directly observe, and in some cases participate in, their practices as well as observe and handle the objects that they used.

Due to the restrictions imposed on me by local oversight agencies (outlined below), I was not able to live with the Palawan people in their ancestral lands as I had hoped to do. Instead, my encounters with the Palawan adults and young people, who were the main subject of my study, were largely through spending days walking around communities, talking to people, conducting interviews, observing and generally 'hanging out'. I also spent a considerable amount of time observing in schools and during breaks or the evening would walk with students to their homes and sometimes spend time with them outside of school hours. As such, I was able to experience what 'mundane' every-day life was like but I also attended more formal events such as weddings, funerals, community meetings, religious ceremonies and the construction of (*Pagpapatayo ng Bahay* in Tagalog) and movement of houses (*Bayanihan* in Tagalog). My interpreters and research assistants were mostly evangelical missionaries and as such, I participated in this aspect of religious life in the community and gained an insight into the missionary activities that were taking place in indigenous communities.

Rather than describing my fieldwork encounter as an example of either immersed and participative or indirect and passive observation, I suggest that a more accurate description would simply be of '*being there*' (Borneman and Hammoudi 2009). By not fully immersing myself to the extent that I lived like and a native Palawan, I was not able to subject *myself* to all of the contingencies that play upon the lives of my participants. This was exacerbated by the fact that I entered, left and re-entered the field many times over the two year period from my initial scoping visit in April 2012 to the last part of fieldwork in February 2014. During fieldwork phases, I situated myself within the community I lived in but, in intervening periods, I returned to what I considered to be my *actual* home and life. However, in these periods of absence, the field was not



forgotten or entirely left as I maintained contact (and still do) with participants and friends in Bataraza through text, email, Skype and Facebook. Rather than being a negative factor, I felt leaving and re-entering the field was an advantage in that it meant participants were often excited and more willing to engage in my project which, especially for those engaged in the photovoice sessions, demanded a lot of their time and attention. I felt the recurring novelty factor of the 'foreigner' returning, actually helped me to practically carry out my project and perhaps more so than if I had slowly become (to the extent one can ever), an *insider* within the community.

'Being there' enabled me to access a broad selection of people, places and events in the community and collect vast amounts of information on practice that allowed me to incrementally build up a well-rounded depiction of life for the Palawan. This was invaluable to my project and meant that, apart from other more standardised qualitative methods described below, I was able to collect an immeasurable amount of information and insight into life in Bataraza. I regularly recorded day-to-day interactions, observations, and informal conversations through field notes and a personal diary and took over 3,000 pictures and videos. Additionally, conversations, particularly emails and texts that I sent to my supervisors, friends and family back home, also acted as an additional way of framing and concretizing my ideas and formed part of the way I experienced the field both while I was there and away. These interactions act as an additional, and perhaps often neglected, way of conducting fieldwork and as an on-going source of reflective data on the process.

### ***3.4.2 Interviews and focus groups***

Throughout fieldwork, interviews, and to a lesser extent focus groups, were one of the most important methods that I used to gain an understanding of practice. While ethnographically observing (and to some degree engaging in) practice is instrumental for capturing bodily movements and artefacts, it offers only a limited insight into implicit knowledge. As Bueger (2014) articulates, a study of practice:

'requires finding and identifying data which allows for conclusions on implicit structures of meaning. Much of this data will be found in articulated meaning, such as in explicit rules, classifications, cultural codes, metaphors, speech acts, representational practices, or discourse.

Although praxiography<sup>2</sup> claims that explicit articulated meaning is only of secondary relevance, in doing praxiography, the researcher *de facto* often needs to primarily draw on this data'

(ibid.: 388-399)

Trying to understand implicit knowledge requires the analysis of the discourse that surrounds practice in order to try to 'identify moments in which participants in a practice . . . articulate implicit meaning themselves' (ibid.: 399). As such, interviews and focus groups provided a crucial means of gathering such discourse. In the first exploratory phase of research, which lasted 3 months, I conducted a number of largely open-ended interviews with health professionals (from both the formal and informal sector); government and education professionals; Chieftains and *panglimas* (leaders) within the Palawan community; and adults and young people in the indigenous community who were predominantly Palawan. Over time, and as themes and issues emerged, these developed into more semi-structured interviews on specific themes and topics. Interviews were always flexible and I tried as far as possible to be guided by participants. In addition, my translator was instrumental in the flow of the interview as, although I directed questions, he often added supplementary or follow-up questions or changed the wording of questions in order to communicate as completely as he could my ideas and elicit relevant information from participants. During the scoping visit and exploratory phase, I conducted about 35 interviews and used them as opportunities to investigate: local perceptions, understandings and practices relating to every-day life; health, particularly malaria; adolescence; and experiences of visual culture and photography. The vast majority of interviews were recorded using a digital dictaphone and those that were conducted in Tagalog or Palawano involved a translator. I transcribed all interviews on the day or within a couple of days of them taking place. Interviews lasted anything from 30 minutes to several hours and took place in a range of places. The majority of interviews with participants from the indigenous community took place in people's home, farm, school or the community hall and interviews with various professionals usually took place in their place of work. This gave me the opportunity to make informal observations whilst conducting interviews.

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<sup>2</sup> Praxiography refers to the study of practices.

During subsequent phases, I used interviews less intensively compared to other methods but did continually interview people and, in particular, conducted around 30 interviews at the end of phase 3 (photovoice) with health professionals, my translators/research assistants, teachers, parents and children following the photovoice sessions in order to evaluate the project.

When conducting interviews with the Palawan, I discovered that there were certain culturally appropriate ways of doing things. For example, every encounter had to begin with a period of '*chicka-chicka*' which roughly translates as gossip or chit-chat. My translator would initiate this and would sometimes spend up to 30 minutes engaged in this kind of general conversation which is convention for the Palawan and necessary for building rapport. Obviously, as an ethnographer, these chats were sometimes even more insightful than the 'interview proper'. Similarly, it was customary for me to bring coffee and food to every interview. Reciprocity is a key feature of Palawan social relations and it would have been discourteous for me to fail to reciprocate people's time and effort. In return for 'choosing' people to be part of my project, I was often given coconuts, pineapples, cassavas or rice desserts. Furthermore, the concept of individual privacy was somewhat difficult to enforce and not culturally appropriate in many encounters. Very few interviews were conducted with individuals alone as often family members or neighbours would be invited by interviewees to congregate around and intermittently contribute or initiate discussion amongst themselves about issues being discussed. In these cases, the distinction between interviews and focus groups was somewhat arbitrary. Finally, the Palawan employ a number of rhetorical devices and strategies in order to think, discuss, deliberate and decide, make judgements, and restore peace (Dy 1991). This was especially relevant when talking to older community members and in particular Chieftains or *panglimas* who would sometimes answer questions in the form of riddles or proverbs. In these situations, I relied heavily on the knowledge and experience of my translator to decode subtle meanings and respond in appropriate ways.

Human practice is a largely inter-subjective process that is enacted in direct co-ordination with, or at least in relation to, others. In this sense, focus groups can be an important means for capturing how groups of people create and crucially, negotiate meaning (albeit in a rather artificial situation). I conducted five focus groups with young

people and parents that were recruited into the photovoice projects. These were more structured than interviews and based around specific themes. I conducted three focus groups with young people - two of which were with groups of exclusively girls or boys. The third group was mixed. Themes revolved around the issues of childhood, daily life, health perceptions, education and photography. With parents, I conducted two focus groups with mainly mothers of children recruited into the photovoice project and concentrated on local perceptions of illness and malaria. For each focus group, between six and 10 participants were randomly selected and invited to attend. Sessions were conducted in Tagalog using my translator and lasted around 1 – 1.5 hours. All sessions were recorded using a digital dictaphone and transcriptions made on the day or within a few days of the event. I also made personal notes and observations on these sessions.

### **3.4.3 Photovoice**

Photovoice was used as Participatory Action Research (PAR) method which allowed me to collect and interpret qualitative data that *depicts and describes* practices with research participants directly. However, rather than simply ‘uncover’ reality, photovoice also enabled participants to *enact* practices and more specifically potentially alter them *in line* with this joint understanding. A much more detailed description of the photovoice element of this project is given in chapter 9. Briefly, photovoice was conducted in two schools with 44 children (28 students in one school and 16 in the other)<sup>3</sup>, with pupils divided into five groups of around seven to ten students in each group. More details of recruitment for photovoice (and questionnaires) are provided below. I conducted a day-long training course for my translators and two teachers from each school as they acted as co-facilitators in the project. Each group of students met once a week on a regular day for 15 weeks and the project was broadly divided into 3 phases. Consistent with the literature on photovoice, the aim of the initial sessions was to introduce the project and methodology; bond the group; and provide basic training of photography and camera use (Wang and Burris 1997; Wang, Yi et al. 1998; Wang 1999). Once young people felt comfortable with the idea of the methodology and the equipment, we embarked on the main component of the sessions – photo-taking and discussion. The first assignment I set participants was to explore the question, ‘how do you stay healthy?’, which they investigated in the first week that they took cameras

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<sup>3</sup> 49 young people were recruited into intervention groups at baseline but five dropped out as discussed below.

home with them. Following this initial exercise, in subsequent weeks, I asked participants to explore the question, 'what does malaria mean to you?'. The exploration of this question continued until the ninth or tenth week. Each week, images were distributed and labelled; looked at and individually or collectively sorted; described by individuals through narratives; and discussed and analyzed as a group. The final five to six weeks of the project were dedicated to refining messages that participants wanted to disseminate using their photographs and to designing and making a range of outputs to facilitate this. All photovoice sessions were conducted in Tagalog using a translator and recorded using a dictaphone. In addition, throughout sessions, I took my own ethnographic notes (both written notes and photographic images) and also held informal interviews with co-facilitators in order to document and evaluate the process. After photovoice sessions, I transcribed transcripts of the sessions 'proper' and also wrote up notes on my own, and facilitators' reflections. In order to evaluate photovoice, in addition to the interviews described above, I also devised a short written questionnaire for participants to complete mid-way through the project.

### **3.5 Quantitative data collection tools**

As well as qualitative data on practices, in this thesis, I also collected quantitative data through a questionnaire in order to help try and assess if there had been a change as a result of the photovoice 'intervention'. I chose to do this as household questionnaires are the most common method for collecting quantitative data related to health practices (Grundy and Annear 2010: 231). I therefore developed two questionnaires for participants that were recruited into the photovoice aspect of the project: one for young people and one for their adult caregivers (see Appendices 1 and 2). The questionnaires were developed following the initial exploratory phase and heavily relied on qualitative data that I collected during this phase. This meant that locally relevant questions could be developed that were grounded in contextual information. The purpose of the questionnaires was to collect socio-demographic data about the sample; data related to knowledge regarding causes, prevention, diagnosis and treatment of fever and malaria; hypothetical and actual practices in response to fever and malaria; and data on issues such as self-esteem, general self-efficacy and malaria self-efficacy which were relevant to the evaluation of the effects of photovoice.

### **3.5.1 A note on existing questionnaires**

Knowledge Attitude and Practice (KAP) questionnaires are widely used in health-related studies including those on malaria (Anh, Hung le et al. 2005; Hlongwana, Mabaso et al. 2009) as a means to evaluate practice. Increasingly however, the limitations of KAP style questionnaires have been well documented (Launiala 2009). Whilst KAP questionnaires are limited in their ability to capture information on health practices *in context*, when coupled with other ethnographic methods, they can still provide useful quantitative data on sociological variables and general information about public health knowledge and practices related to treatment and prevention (ibid.). No detailed examples of malaria KAP questionnaires were found in the literature that were specific for the Philippines, so examples used in other settings provided a useful guide for the development of some questions in this questionnaire. In particular, the questionnaire included in a PhD thesis by Hausmann-Muela (2000) has been used as a guide for some questions.

In terms of assessing malaria-related practices, the standard tool adopted in many malaria endemic countries is the Malaria Indicator Survey (MIS) which was developed by the Monitoring and Evaluation Working Group of Roll Back Malaria. As a stand-alone household questionnaire, the MIS collects national and regional or provincial data from a representative sample of respondents (Measure DHS 2012). MIS collects data on all of the internationally recognized malaria indicators including household ownership and use of nets and the type and timing of treatment for high fever in children under five. In addition, MIS collects data on the characteristics of household members and ownership of household assets (ibid.). Although standardized malaria indicators are available for nearly 30 countries, nothing has been developed for the Philippines (ibid.). While the MIS questionnaire has some useful basic questions that I adapted for use in my questionnaire, many sections were not relevant for my study and were thus excluded. A few questions are dedicated to treatment of fever for children under five, but these are limited to recording use of official services and drugs. As such, they would not have provided detailed enough data that were important for my study regarding the choices made by young people or adults; their expectations and views on the effectiveness of treatment; and young people's agency in making decisions or seeking treatment. As this questionnaire is for adults only, I felt many questions might be hard for young people to

answer such as those about agencies responsible for coordinating and providing services like distributing nets and house spraying etc.

The Malaria Manual developed by Agyepong, Aryee et al. (No year) provides a detailed guide to conducting rapid assessment of the social, economic and cultural aspects of malaria and has been validated for use in the Philippines. Although the guide focuses more on qualitative methods, it does provide some guidelines for the development of and an example of a cross-sectional questionnaire on community perceptions of malaria. I used this as a guide for the development of some questions as it was the most locally relevant example I found. However, again, questions have been adapted or expanded upon to fit the specific needs of my questionnaire.

As none of the questionnaires mentioned above were specifically for young people and served slightly different purposes in different contexts, none presented a viable option to use in their entirety here. Rather, existing questionnaires have provided a guide, alongside preliminary qualitative work.

### ***3.5.2 Developing, translating and piloting the questionnaire***

As mentioned above, I developed two questionnaires for participants recruited into the photovoice part of the study: one for young people and one for their adult caregivers. Although they are broadly similar, there are some differences that are explained below. The questionnaires are divided into eight parts: Part 1 on general and socio-demographic information; Part 2 on fever knowledge and practices; Part 3 on medicines for fever; Part 4 on malaria knowledge and practices; Part 5 on medicines for malaria; Part 6 on mosquitoes and nets; Part 7 on self-esteem and Part 8 on self-efficacy (see Appendices 1 and 2).

#### ***3.5.2.1 Part 1: General information***

In the questionnaire for young people, questions one-13 in Part 1 were included to gather basic demographic data since factors such as sex, education level, age etc. have been shown to be important factors that influence health. Although absolute biological age is included in the vast majority of health related questionnaires, here questions were also included to try to determine the relative age of participants. Ethnographic work revealed that many participants, particularly older members of the community, were not aware of their absolute age in years. Furthermore, I found that relative age

was an important factor in determining young people's identity and health-related practice. Questions 14 and 15 were designed to gather general information on young people's perceptions of health problems in their village.

In the adult questionnaire, questions on relative age were omitted and additional questions included in order to determine socio-economic status including water/sanitation facilities as well as household possessions. These were adapted from the MIS as a means of assessing wealth index. These questions are thought to be more reliable than questions on household income but were not included in the questionnaire for young people as I perceived it might be hard for them to answer such questions.

#### ***3.5.2.2 Parts 2-6: Knowledge, practices and medicines related to fever and malaria***

Preliminary qualitative work suggested that, in this context, fever continues to be largely synonymous with malaria but was also recognised as a common symptom for other illnesses. For this reason, I included separate sections on fever (parts 2 and 3) and malaria (parts 4 and 5) in an attempt to try and disentangle the rationale that distinguishes the fever that relates to malaria compared to other diseases. Most questions that related to fever and malaria were exactly the same with some additional questions on sources of information about malaria (question 4.3); malaria prevention (question 4.5); and expectations of services related to malaria (question 4.11 in the questionnaire for young people and 4.10 in adult questionnaire).

In part 2 (knowledge and practices relating to fever) and part 4 (knowledge and practices relating to malaria), questions were designed to gather general information on participants' perceptions of the severity of illness and perceived risk in their village as well as the causes of fever/malaria. These are common questions in health questionnaires and I chose to use an 'agree-disagree' response scale that ranged from 'strongly disagree' to 'strongly agree' to collect responses. These were translated into locally understandable terms.

The majority of questions in these parts were designed to gather data on both hypothetical and actual treatment seeking for fever/malaria. These questions followed a similar format to those suggested in the Malaria Manual (Agyepong, Aryee et al. No year), i.e. first response.



Although hypothetical questions regarding practices have been shown to be notoriously unrelated to actual future practice, I felt it was still worth including these questions for a number of reasons. First, they provided a comparison to the responses elicited about actual experience and so provided extra evidence regarding the validity of different kinds of questions in questionnaires. Second, hypothetical questions provided useful insights into normative ideas and practices. Third, I anticipated that many respondents may not have had malaria (and even possibly fever) in the last 30 days due to low transmission levels which would exclude them from answering many of the questions related to treatment seeking practices were it not for hypothetical questions.

For every stage of treatment-seeking, I included a question regarding whether or not young people would take action alone (i.e. without an adult). This was in order to elicit some data regarding young people's agency in their own health practices but these questions were excluded from the adult questionnaire.

In terms of questions that relate to actual treatment practices, the MIS uses a timeframe of two weeks; however, this is not suitable for this context where there is a lower incidence of malaria (and possibly fever) as compared to most of the countries where the MIS questionnaire is used. Although using a longer time period of 30 days has implications for the recall bias of respondents, it was balanced against the need to collect data on past experiences in an area where malaria cases are relatively low and the study sample size is small.

Questions in part 3 (Medicines for fever) and part 5 (Medicines for malaria), were designed to gather data on participants' knowledge of and use of 'herbal' and 'allopathic' medicine. As in all other questions which ask for a 'Yes' or 'No' response, a 'Not sure' option was also included so as not to force people into an answer.

Questions in part 6 (Mosquitoes and nets) relate to net use and care, perceptions regarding mosquitoes and preventative actions taken against mosquitoes. These are similar to other questions asked in questionnaires such as the MIS. As far as possible, questions have been adapted to use an 'agree-disagree' scale.

### **3.5.2.3 Part 7: Self-esteem**

Both self-efficacy and self-esteem were assessed in the questionnaire as these outcomes are pervasive in many descriptions relating to behaviour change or youth empowerment programmes (Morton and Montgomery 2011).

I used a modified version of the ten point Rosenberg Self-Esteem Scale (RSE) (Rosenberg 1965) to assess self-esteem of both young people and adults before and after photovoice. The RSE is the most widely-used self-esteem measure in social science research (Flynn 2003). It is an attempt to achieve a unidimensional measure of global self-esteem that is applicable cross-culturally (ibid.). It was designed to be a Guttman scale, meaning the RSE items represent a continuum of self-worth statements ranging from statements that are endorsed by individuals with low self-esteem to statements that are endorsed only by persons with high self-esteem. However, the scale is now commonly scored as a *Likert scale* meaning the ten items are answered on a four-point scale ranging from 'strongly agree' to 'strongly disagree' (University of Maryland 2012). For the analysis, responses to all nine items are summed up to yield the final composite score, with a range from 0-36.

The scale was originally used amongst adolescents in New York State (Rosenberg 1965) and has since been translated and utilised in numerous studies with young people including those in the Philippines (Dimar 2011). Multiple studies have been conducted to investigate the validity and reliability of the RSE. However, the theory and measurement surrounding a subjective concept like self-esteem is problematic (Flynn 2003). Furthermore, it is debatable whether or not the scale has true cross-cultural applicability as most self-esteem theory reinforces masculine, Euro-American values that have an individualist predisposition (ibid). These issues are considered in further detail in chapter 10 where I discuss the results of the scale in this study. The RSE scale was the most challenging aspect of the questionnaire to translate and during the piloting process, question 8 from the original scale ("I wish I could have more respect for myself") was omitted as I found that many respondents did not understand the question and struggled to differentiate it from other questions. Despite the limitation of the RSE scale, I chose to use it as it represents a globally recognised (and therefore comparable) tool for quantitatively evaluating self-esteem.

#### **3.5.2.4 Part 8: Self-efficacy**

The General Self-Efficacy (GSE) scale (Schwarzer and Jerusalem 1995) is a commonly used scale to assess self-efficacy. It was created to predict how well individuals can cope with daily life as well as adaptation after experiencing various kinds of stressful life events (ibid.). In my questionnaire, I used ten questions which form the standard scale to assess general self-efficacy before and after photovoice amongst both young people and their adult caregivers. Responses are made on a four-point scale. For the analysis, responses to all ten items are summed up to yield the final composite score, with a range from ten to 40 (ibid.).

There are number of studies which have used the GSE scale to measure self-efficacy and assess its potential in initiating change to health-related practice. Luszczynska and Schwarzer (2005) recommend that, for these kinds of study, the following semantic structure: 'I am certain that I can do xx, even if yy (barrier)' (ibid.) is used to develop specific health related self-efficacy questions. Consequently, for the questionnaire, I developed 16 questions following this format in order to gather data on self-efficacy specifically related to both fever and malaria for young people (only ten of these questions were relevant to adults).

#### **3.5.3 Recruitment and sampling**

For the photovoice sessions and questionnaires, participants were selected from four elementary schools in two *barangays* in Bataraza (Inogbong and Bonobono). *Barangays* were selected following discussions with local health staff who advised regarding areas which were considered highly endemic ( $\geq 1$  case per 1,000 population) in terms of malaria transmission. Within each *barangay*, two schools were selected and then randomly assigned to control and intervention groups using a coin toss. Schools were selected based on criteria that included: location in *barangays* that had highest rates of malaria in Bataraza in 2012; location in the same *barangay*; similar distance from health services (in Bonobono, Iniam and Taysay are located about 1km from the *Barangay* Health Station (BHS) and 6km from the Rural Health Unit (RHU) and in Inogbong Matyag and Papan are 1km from the BHS and 7km from the RHU); similar ethnic population; similar ecological setting; community recognition of malaria or febrile illnesses as one of the major problems affecting young people; and school and community willingness to participate in the study. In Inogbong, 29 young people were

recruited from the top grades of 3, 4 and 5 in the intervention school (Matyag Elementary School) and 40 from the same grades in the control school (Saray Elementary School). In Bonobono, 20 young people were recruited from the top grades of 3 and 4 in the intervention school (Taysay Elementary School) and 24 from the same grades in the control school (RVEMS). The total population (for photovoice and questionnaires) at baseline consisted of 113 young people.

In addition, one adult from each young person's household was invited to participate. In total, 83 adult caregivers were recruited at baseline. In cases where caregivers living in the same household were not able to participate, adults who lived outside the young person's household but who also contributed to care giving were permitted. Only one caregiver did not live in the same house as the young person. There were fewer caregivers than young people as 16 young people did not have an adult present for either recruitment or to conduct the baseline questionnaire. This was most commonly because adults were away, sick, or busy on either the allotted recruitment or questionnaire day. Similarly, the children of four caregivers who were surveyed at baseline, did not present for either recruitment or to conduct the baseline questionnaire. This was due, on the most part, to absenteeism because of illness or the need to work on their family farms. The discrepancy between adolescent and caregiver numbers is also explained by the fact that fourteen caregivers had more than one child recruited into the study. Questionnaires were administered to both young people and adult caregivers from control and intervention groups in Tagalog using trained translators.

### ***3.5.4 Descriptive statistics of photovoice/questionnaire sample***

#### ***3.5.4.1 Young people***

**Figure 3.2: Table showing characteristics of school children in each of the four groups/schools.**

<b>Characteristic</b>	<b>Intervention 1 (Matyag) n=29</b>	<b>Control 1 (Saray) n=40</b>	<b>Intervention 2 (Taysay) n=20</b>	<b>Control 2 (RVEMS) N=24</b>	<b>p-value</b>
Sex, n (%)*					0.222
Male	10 (34.5)	16 (40.0)	11 (55.0)	6 (25.0)	

Female	19 (65.5)	24 (60.0)	9 (45.0)	18 (75.0)	
Age (yrs), Median (Range) **	12 (10-14)	12 (8-17)	12 (9-13)	10 (8-14)	0.179
Grade, n (%)*					<0.01
3 <sup>rd</sup>	5 (17.2)	16 (40.0)	9 (45.0)	8 (33.3)	
4 <sup>th</sup>	9 (31.0)	18 (45.0)	7 (35.0)	16 (66.7)	
5 <sup>th</sup>	15 (51.7)	6 (15.0)	4 (20.0)	0 (0.0)	
Ethnicity, n (%)*					<0.01
Palawan	14 (48.3)	37 (92.5)	20 (100)	24 (100)	
Other	15 (51.7)	3 (7.5)	0 (0.0)	0 (0)	

\* Pearson's chi-squared test used at 0.05 level of significance. See text for result statistics

\*\* Kruskal-Wallis Test used at 0.05 level of significance. See text for result statistics

A total of 113 young people (43 boys and 70 girls) were surveyed at baseline in this study: forty-nine from the two intervention schools<sup>4</sup> and 64 from the control schools. Factors like age, sex, school grade ethnicity have been shown to impact health knowledge and practices so any differences at baseline could account for differences seen after young people's engagement in photovoice. No statistically significant baseline difference was found between the four groups in terms of sex (Pearson's chi-squared=4.393, df=3) or age (Kruskal-Wallis Test Chi Squared =4.903, df=3) (Figure 3.2).

However, there was a statistically significant difference found in the school grade of young people across all four groups (Pearson's chi-squared=25.583, df=6) (Figure 3.2) as well as between intervention and control groups (Pearson's chi-squared=14.129, df=2, p<0.01). As far as possible, young people were recruited from the highest grades in schools as I perceived there may be difficulties in involving younger children in the photovoice intervention. As participants were involved in the study over an 18 month period, in which time they would move up a grade, initial recruitment excluded those from the highest grade (either 5 or 6 depending on the school) as they would not be enrolled for the duration of the project. One of the intervention schools (intervention school 2, Taysay) was newly established and only had students enrolled up to a grade 5 level so adolescents were initially recruited from grade 4 and below. The same was

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<sup>4</sup> Only 44 young people participated in the photovoice project as five dropped out as described below.

done in the matched control (control school 2, RVEMS). As a result, there is a significant difference between pairs 1 and 2.

As well as between pairs, there was also a statistically significant difference in grade *within* pair 1 (Pearson's chi-squared=11.149, df=2, p=0.004) and pair 2 (Pearson's chi-squared=7.277, df=2, p=0.026). Two schools had a lower number of higher grade students enrolled (intervention group 2, Taysay and control group 1, Saray) as they are located in areas where people were likely to marry younger and therefore stop attending school (as described in more detail in chapter 8). Subsequently, teachers reported that they felt they had problems in engaging local communities and retaining students in higher grades which could explain this difference within both pairs. In addition, following initial recruitment, four students from intervention group 2 (Taysay), dropped out as three moved away to a different area and one decided they did not want to take part following the first session. As four new students had also joined the class since initial recruitment, they were recruited at a later stage by which time they were already in Grade 5. This further contributes to the statistical difference in grades within pair 2.

As discussed in chapter 8, grade does play a role in the way in which young people's identity and health practice is enacted. However, taken alone, it is unlikely to have had a particularly significant impact on results. Membership in a school grade is determined by educational ability meaning young people are grouped together in new configurations which run parallel to, and sometimes against, pre-existing networks of relatedness like relative age and generation. Within the Palawan context these are very strong social forces in governing much of both identity and practice both within and outside of the school domain. In many ways, these patterns of relatedness take precedent to those created by school grade which is a much more recent phenomenon amongst the Palawan.

As well as grade, there was also a statistically significant difference in the ethnicity of young people across all four schools (Pearson's chi-squared=38.205, df=3) (Figure 3.2) as well as between intervention and control groups (Pearson's chi-squared=13.938, df=1, p<0.01). One hundred percent of adolescents from pair 2 (Taysay and RVEMS) were from the Palawan ethnic group. However in pair 1 (Matyag and Saray), there was

also a statistically significant difference (Pearson's chi-squared=17.052, df=1,  $p<0.01$ ). These results are probably explained by the ethnic composition of young people from intervention school 1 (Matyag). Although migration and intermarriage are present in all villages included this study, this was more prevalent in the area of Matyag with a higher number of participants reporting that they were from other ethnic groups. As Matyag is located near the shore, there is a longer history of migration to this area of Muslim Taosug traders from the Sulu Archipelago. In addition, in more recent years, Mayor Hon. Hadji Abraham M. Ibba has bought a significant amount of land in the area of Matyag which was leased to migrant members of his family.

Ethnicity is an important factor in terms of both identity and health practice. However, my ethnographic work suggests that the reporting of ethnic identity in questionnaires is problematic throwing into question the implication of these results. There was a strong sense of shame amongst participants in acknowledging their Palawan ethnic identity due to the marginalisation and subjugation of indigenous groups in Palawan. This was reported to me by participants directly but also by my translators/research assistants who detected a certain amount of caution and embarrassment in the way participants answered questions relating to ethnic identity. In the cases where participants' had at least one non-Palawan parent (or a non-Palawan spouse), they tended to report their ethnic identity in line with this (e.g. Bisaya or Tausūg). This could also explain some of the inconsistencies that I found between the responses given by adults and their children or by the same respondents in baseline and follow-up questionnaires. Furthermore, some respondents also conflated ethnic identity with religion and responded that they were 'Muslim' or 'Christian' in response to this question. Despite intermarriage, migration and religious conversion, many respondents still retained many of their beliefs and practices that relate to 'traditional' Palawan culture which no doubt has a large impact on identity and practice. This suggests that the de-contextualised responses from the questionnaire relating to ethnic identity are less likely to be reliable indicators of what is in reality, a very complex social issue. This in turn, lessens the impact of a statistical significance in this variable at baseline.

### 3.5.2.2 Adult caregivers

**Figure 3.3: Table showing characteristics of adult caregivers of school children in each of the four groups/schools.**

Characteristic	Intervention 1 (Matyag) n=22	Control 1 (Saray) n=29	Intervention 2 (Taysay) n=13	Control 2 (RVEMS) N=19	p-value
Sex, n (%) <sup>*</sup>					0.096
Male	2 (9.2)	8 (27.6)	1 (5.3)	1 (5.3)	
Female	20 (90.9)	21 (72.4)	12 (92.3)	18 (94.7)	
Age (yrs), Median (Range) <sup>**</sup>	40.50 (24-65)	37 (18-89)	30 (25-40)	30 (22-48)	0.020
Education, n (%) <sup>*</sup>					0.194
Elementary	15 (68.2)	23 (79.3)	6 (46.2)	12 (63.2)	
High School	2 (9.1)	0 (0.0)	0 (0.0)	1 (5.3)	
No education	4 (18.2)	6 (20.7)	7 (53.8)	6 (31.6)	
Marital status, n (%) <sup>*</sup>					0.622
Married	21 (95.5)	25 (86.2)	12 (92.3)	18 (94.7)	
Not married	1 (4.5)	4 (13.8)	0 (0.0)	1 (5.3)	
Occupation, n (%) <sup>*</sup>					0.052
Occupation	10 (45.5)	23 (79.3)	9 (47.4)	50 (60.2)	
No occupation	12 (54.5)	6 (20.7)	10 (52.6)	33 (39.8)	
Ethnicity, n (%) <sup>*</sup>					<0.01
Palawan	11 (50.0)	28 (96.6)	13 (100)	17 (89.5)	
Other	11 (50.0)	1 (3.4)	0 (0.0)	2 (10.5)	

\* Pearson's chi-squared test used at 0.05 level of significance. See text for result statistics

\*\* Kruskal-Wallis Test used at 0.05 level of significance. See text for result statistics

Adult participants recruited into the photovoice/questionnaire aspect of this study consisted of 83 caregivers (12 men and 71 women) at baseline. Thirty five were from the two intervention areas and 48 from the control areas. No baseline difference was found between the groups in terms of sex (Pearson's chi-squared=6.3343, df=3) (Figure 3.3)

In the intervention groups, the median age was 35 (range 24-65) and 35 (range 18-89) in the control schools and there was no baseline difference in age between the intervention and control groups (Mann-Whitney U=544.000, Z=-0.716, p=0.474). There was no baseline difference in age within pair 1 (Mann-Whitney U=188.500, Z=-1.011,



$p=0.312$ ) and within pair 2 (Mann-Whitney  $U=82$ ,  $Z=-0.297$ ,  $p=0.790$ ), but there was a statistically significant difference in the age of adults across all 4 schools (Kruskal-Wallis Test Chi Squared =9.800,  $df=3$ ) (Figure 3.3).

The majority of adults had completed at least some grades of elementary school (67.5%) and 27.7% had no education at all (Figure 3.3). Only one adult had attained college level education. There was no statistically significant difference found in educational attainment between those who had reached elementary level education and those who had not (Pearson's chi-squared=4.710,  $df=3$ ) between all four groups of adults.

The majority of adults were married (91.6%) and there was no statistically significant difference found in those who were married and those who were not (Pearson's chi-squared=1.766,  $df=3$ ) (Figure 3.3) between all four groups of adults.

The majority of adults engaged in some form of occupation, mainly farming or casual labour (60.2%) while 39.8% did not engage in any work (Figure 3.3). There was no statistically significant difference found in whether or not adults had an occupation between the four groups (Pearson's chi-squared=7.735,  $df=3$ ).

The majority of adults were from the Palawan ethnic group (83.1%) but there was a statistically significant difference in the ethnicity of adults across the 4 schools (Pearson's chi-squared=24.130,  $df=3$ ) (Figure 3.3) as well as between intervention and control groups (Pearson's chi-squared=9.151,  $df=1$ ,  $p<0.01$ ). As with young people, within pairs, there was no difference in the ethnicity of pair 2 (Pearson's chi-squared=1.460,  $df=1$ ,  $p=0.227$ ) but there was in pair 1 (Matyag and Saray) (Pearson's chi-squared=15.067,  $df=1$ ,  $p<0.01$ ). The reasons for and implications of these differences are the same as those outlined above in relation to young people.

### **3.6 Ethics, confidentiality and the use of pseudonyms**

Gaining formal ethical approval has become a standard procedure for anthropological research in many countries and institutional ethics committees now provide oversight and approval for proposals prior to their commencement. In line with this, before going to the field, I obtained ethical approval from the Department of Anthropology at the University of Durham in the UK.

In addition, the Philippines has established National Ethical Guidelines for Health Research which state that all research requires ethical clearance from the Principal Investigator's Filipino Institution or from a Regional Ethics Committee. I partnered with Dr. Espino, Head of Department of Parasitology and National Reference Laboratories for Malaria and other Parasites from the Research Institute of Tropical Medicine (RITM) in Manila in order to facilitate the process of obtaining clearance from the Institutional Review board (IRB) at RITM as at the time of research all Regional Ethics Committees had been disbanded.

Informed consent is of central importance in all academic research. Accordingly, one of the main requirements of the IRB was that detailed written consent forms were developed and signed by all participants involved in the study. While this was straightforward enough to put together for participants involved in the photovoice project, control groups and those with whom I conducted formal interviews or focus groups, it was not really possible to gain written informed consent from *all* participants involved in the study. This requirement was somewhat at odds with other established guidelines for social research which recognise that it will not always be possible, relevant or desirable to obtain informed consent for observations, spontaneous encounters or large events (ASA 2011). The insistence on written consent from the IRB runs the risk of distorting less formal ethical codes of conduct that researchers need to employ at all times and with *all* participants that they interact with regardless of whether or not formal written informed consent has been obtained.

Even when written permission is obtained, consent and ethical codes are not fixed and need to be re-visited and renegotiated throughout the whole fieldwork process (ibid.). In line with this, I adhered to less formal ethical codes of conduct and was mindful that, 'multiple ethical moments' arise in the field and need to be continuously addressed through reflexive awareness (Simpson 2011). This was especially so because of the implications that written consent had in this local context. Many Palawan have had negative experiences with government officials and mining companies, mostly related to land and resources and have been forced to give their consent on a number of issues that have been detrimental to them. Although I did not encounter any major objections that could not be overcome through dialogue, asking largely illiterate people to sign consent forms, did rouse initial suspicion from them regarding my intentions. For

example, when I first arrived, participants suspected I was a 'treasure hunter' who had come to dig their land for Japanese gold said to be buried all over Palawan island. Due to my interest in health, some people were also suspicious that I was planning to 'steal' herbal medicines or knowledge to develop into commercial drugs. While I was able to assuage these concerns and all participants agreed to sign written consent forms, it was important for me to constantly reassure participants verbally regarding the implications of their consent, as well as their right to withdraw from the study at any time.

In addition, specifically for this study, I adhered to more general ethical codes regarding working with young people and followed recommendations made in the literature in order to 'do research right' (Robson, Porter et al. 2009). For example, participants were informed that there was no financial compensation in return for their involvement in this study.

Another major aspect of ethical codes in research is the issue of confidentiality and anonymity. With regard to identifying information, during the consenting process, I informed participants that all names and identifying information would not be revealed with narratives or photographs included in any presentations, reports or publications unless any participant specifically requested the use of their first names or pseudo-names. I also discussed the possible negative impacts of having their information made available. Despite this, nearly all of the participants that I engaged with for this thesis requested that their real names be used as they felt this was an important dimension of the project. This was particularly so for participants who conducted photovoice (and those that were captured in images), as they happily acknowledged that they were easily identifiable through their images in any case and therefore welcomed their real names being used in accordance. This was articulated as being for two reasons. Firstly, they felt that they wanted to be appropriately credited and secondly because this was more in line with the participatory nature of the project. As far as possible, I have used participants' real names in line with their explicit requests. However, where participants did not make this explicit, I have used pseudonyms and have refrained from using any identifying information alongside information that I judged to be sensitive or deeply personal in nature so as to minimise any potential harm to participants.

As well as the IRB, it was also a requirement for me to gain other approvals for my research as the area of Bataraza is located within the Mantalingahan Protected Landscape (MMPL) and I was working with Indigenous Peoples (IPs). As such it was necessary for me to gain a research permit from the Protected Area Management Board (PAMB) of MMPL. The MMPL is a notoriously slow and the process of gaining a permit was protracted and bureaucratic. However, in order to comply with their requirements and secure a permit, I obtained Free, Prior, Informed Consent (FPIC) from the communities that I worked in as well as Municipal and *barangay* resolutions.

### **3.7 Data analysis**

The majority of data for this thesis were qualitative in nature. In order to analyze it, I opted to conduct manual thematic analysis. Although I investigated using digital software to sort and analyse data (namely NVivo), I decided on the manual option as I felt this allowed me to stay closer to the data and, as is consistent with the aims of qualitative data analysis, better ensure that themes were inductively derived. Accordingly, I typed up all of my digitally recorded transcriptions, hand written notes and reflections as soon as possible after the data were collected. I checked much of the translation of specific terms with my translator. I read and re-read data multiple times in order to familiarise myself with it. I then generated a set of initial themes or codes and re-read the text multiple times to search for and mark codes. The process of reading through data, identifying themes and developing and linking codes was iterative and went through many stages of review and edit. This was especially the case as I carried out my research in stages which meant I had periods in-between data collection in which to conduct analysis and initial writing.

In terms of quantitative data, I entered all data into the statistical software package SPSS, screened them for errors and cleaned them in order to adjust mistakes which were made during data collection or reporting. The data were explored using descriptive statistics and then analysed using a number of tests in order to analyse relationships.

### **3.8 Conclusion**

In this chapter, I have described how and why I used a number of methods in the field to reveal different elements of practice. While ethnographic research methods like

observation and photovoice as well as quantitative methods like questionnaires helped to *depict* bodily movements and the artefacts involved in how people *do* practice, what people *said* in informal discussions, interviews, focus groups and narrations during photovoice, gave me access to the implicit meanings relating to this doing. In combination, these methods helped give a more rounded picture of how practice is done. This is coupled with the other explicit aim I had of altering practice. In order to achieve this, I used photovoice as a method of Participatory Action Research. In this context photovoice was used as a means of not simply 'depicting' practice but also potentially altering it. A mixed-methods approach (i.e. a combination of ethnographic methods and quantitative surveys) was taken in order to evaluate its success in doing so and this is discussed further in chapters eight, nine and ten.

# Part 1

## Chapter 4: The malarias of governance

In this chapter and the subsequent two chapters, I explore what malaria *is* in Bataraza. Here, I describe how biomedical conceptions of malaria came to the Philippines through colonial encounters and continue to feature in current ‘official’ health programmes. In the Philippines, neoliberal economic policies have led to the decentralization of government. In relation to health care, this has meant that local government leaders and health professionals are tasked with implementing and delivering global malaria targets and administering financial plans. Within the context of local political structures, agendas and players, the malarias of health staff, although somewhat ‘biomedical’ in nature, do not represent a unified and uncritical acceptance of hegemonic discourse (Parker and Allen 2014). Instead, examining local contexts reveals that multiple ‘biomedical’ malarias are actively produced, reproduced and even negotiated and contested by the practices of various health professionals. Nevertheless, malarias of governance are united in some ways. For example, health professionals prioritise these malarias over other pressing health concerns that they also recognise need attention. These malarias are thought of and enacted as though they can be overcome and eventually ‘eliminated’ with largely technical solutions despite the reservations that some leaders have about these goals and difficulty they encounter implementing them on the ground. Furthermore, health staff push forward with education campaigns aimed at ‘teaching’ individuals ‘correct’ biomedical knowledge whilst simultaneously acknowledging the multiplicity of disease that they know exists. Following Parker and Allen (2014), I suggest that this ‘dissonance’ needs to be situated in the context of local political and economic factors which reveals that the prioritisation of certain discourses and enactments can help health professionals to fulfil their own strategic agendas (ibid.) within highly politicised contexts.

### 4.1 The wider context of malaria control in the Philippines

Current ‘official’ efforts to tackle the malaria in Bataraza are enmeshed in cultural, social, political and economic structures and processes that operate on a global, national and local level. These have undergone dramatic reform historically, particularly in the

past few decades affecting the way in which malaria is thought of and enacted and the form and implementation of programmes designed to tackle it.

A significant factor affecting current control programmes is the legacy of colonisation in the Philippines which brought with it significant changes to both health and health care. As a result, a number of authors have described the consequences of Spanish colonisation (1565 to 1898) and American occupation (1898-1946) on health. For example, De Bevoise (1995) documents the historical processes that dramatically increased the probability of contact between Filipinos and infectious diseases including malaria in the mid-19<sup>th</sup> century. Although contact with Spain did not wreak as much epidemiological havoc in the Philippines as it did in the Americas, it still brought about substantial death and destruction (ibid.: 20). As well as epidemiological changes brought about by colonisation, the presence of the Spanish no doubt also interacted with local understandings and practise relating to health. Spanish chroniclers and friars documented detailed accounts of medicinal plants and their uses by various types of 'traditional' healers (Tan 2008). These practices would have interacted with European biomedical ideas which were beginning to be established in the Philippines by the end of the 19<sup>th</sup> Century, as evidenced by the opening of the College of Medicine in the University of Santo Tomas in 1871.

The effects of colonial interactions on health have been more extensively documented in the period following Spanish influence when American occupiers, guided by a strategy of 'benevolent assimilation', used biomedicine as a means of both assuaging and civilising what were often referred to as Filipino 'savages' (McElhinny 2005). This strategy was motivated, not only by a desire to demonstrate good intentions and pacify Filipinos in the face of colonisation but also by a US sense of an enlightened missionary endeavour to bestow the precious gift of civilisation onto 'savages' (ibid.). Consequently, universal primary education in English was established, investment made in sanitation and transport and the Filipino nationalist movement repressed in order to 'develop' the islands (Cannell 1999). Within this context, McElhinny (2005) describes how numerous tracts referred to Filipinos as children: 'highly impressionable, unable to reflect on their own conditions, and capable only of mimicking the actions of those above them' (ibid.: 35).

Many authors have highlighted how American colonial medicine had the more menacing effect (or purpose) of rationalising the 'white man's burden' overseas with the insidious aim of transforming Manila into a healthy, habitable city for U.S. citizens (ibid: 3-4). As in other colonial encounters, much attention was focused on battling infectious diseases, in particular malaria, cholera, smallpox, leprosy, and the bubonic plague that afflicted Filipinos but more significantly, colonisers (De Bevoise 1995; McElhinny 2005). Within this context, American medical laboratories were established to investigate the 'truth' about the 'tropics'. By becoming the authoritative voice on these matters, their emergence further facilitated colonial legitimacy. Over time, these laboratories rendered US imperialism as 'simultaneously powerful and benign' (Anderson, 1995). By 1902, government laboratories namely the Manila Bureau of Science (formed in 1905) and the Army Board for the Study of Tropical Diseases (housed inside the Bureau of Science from 1906), conducted experiments to compare Filipino and American adaptations to the tropics. Initially, the environment was implicated as the main cause of diseases and ill-health and efforts were invested in helping colonizers to acclimatize. Later, as biomedical discoveries were made, attention shifted to the role of microbial pathogens. By the turn of the century, American physicians almost universally subscribed to germ theory which gave rise to a kind of aggressive warfare against disease-causing microbes (Ileto 1995: 60).

For example, Ronald Ross discovered the link between *Anopheles* mosquitoes and malaria in 1897, challenging the view that the disease was due to physical imbalance caused by the environment (ibid.: 89-90). The Army Board in the Philippines set about diagnosing potentially malarious fevers and found that malaria parasites were commonly found in the blood of lowland Filipinos, especially children. Filipino bodies that contained parasites posed a threat to white bodies but these were relatively easy to control through strict sanitary regimes. Thus, 'tropical science managed to convert the dirty, humid, teeming, complex environment into controllable specimens and measurements, which were further consolidated as figures in the scientific paper' (Anderson 1995a: 99). Safety would be achieved not only by the avoidance of climate, but by the restriction of contact with 'tropical' fauna that included Filipino bodies (ibid.: 101). As a result, colonial laboratories played an important role in constituting Euro-American physical and cultural authority as 'the economic and political aspects of



American colonialism in the Philippines [were] rapidly . . . translated into the language of medical science' (Anderson 1995a: 83-84).

The literature presented above represents some recent examples aimed at countering the exceptionalism of US colonial historical accounts. Additionally, the popular conceptualization of Euro-American medicine as a positive universal humanitarian effort (McElhinny 2005) has often led to a dearth of critiques regarding some of the arguably exploitative and detrimental aspects of American colonisation. However, while colonialism has been significant in shaping health, and more specifically malaria in the Philippines today, it is only part of the story – a largely recorded part – and a focus on this should not mask the sheer complexity of how malaria and malaria control has historically developed but also currently exists.

Today, biomedicine still pervades public health discourse and activities in the Philippines. However, there is also acknowledgment of the plurality that actually exists as the World Health Organisation and Philippines Department of Health make explicit:

'Health service delivery is based on a Western biomedical model of health initially introduced during the Spanish colonial era and strengthened during American colonization. This Western system is superimposed on a pre-existing alternative model of health care based on a mix of folk and herbal medicines, religious beliefs, and traditional practices that has persisted throughout the country'

(WHO/DOH 2012)

As shown throughout the course of this chapter, while 'biomedical' conceptions of malaria still permeate 'official' control programmes, they are neither singularised nor coherent conceptions that are passively and uncritically accepted by health leaders. Instead, multiple 'biomedical' malarias are actively produced, reproduced and even negotiated and contested by various health staff for somewhat strategic reasons that need to be situated within current local political and economic contexts.

In more recent history, the late 20<sup>th</sup> Century saw the increasing prominence of neoliberalism as a form of governance in many countries around the world. This economic philosophy is grounded in ideas of 'liberalized trade and investments,

lowered tariffs on imports, wage suppression for global competitiveness, privatization, reduced government intervention, and business deregulation' (Paterno 2013: 9). This global ideology is now dominant in the Philippines and continues to inform health policy and practice. The 1980s saw the end of the authoritarian Marcos regime and associated martial law in the Philippines. Alongside a transition to democracy, the country experienced a rapid drop in Gross National Product (GNP) between 1980 and 1999. By 1987, over half of the government's budget was directed at repaying its USD 26 billion debt, owed to largely western financial institutions (Stuckler and Siegel 2011). Overall public funding shrank, and by 1991, healthcare accounted for just 2.7% of the GNP (ibid.). As in other contexts that have undergone similar structural adjustments, this resulted in 'lowered government health expenditure, introduction of user fees, fiscal autonomy for government hospitals for income retention, and safety nets in the form of social health insurance' (Paterno 2013: 9).

In terms of the structure of healthcare, 'the Department of Health (DOH) was carved out of the colonial Health and Public Welfare Bureau and, as described above, broadly adheres to a biomedical view of health and disease which guides much of its activities. The 1954 Rural Health Act established a nationwide network of Rural Health Units based in the municipalities (towns) and city health centres in the cities' (Paterno 2013: 2). In 1979, the Philippines signed up to the Alma Ata Declaration, which 'provided a manifesto for mass access to health care that linked poor health with poverty, and proposed responses that moved away from relying on largely biomedical solutions to lessen the burden of ill-health' (Parker and Allen 2014: 226). The primary health care (PHC) approach was adopted and the 'Primary Health Care and Health for All by 2000' became national health policy (Paterno 2013: 2). Under a then centralised health system, this integrated public health and hospital services and arranged local services into health districts. However, over time, this more holistic approach has been gradually dissolved by a range of other policies that aim to reduce child mortality through predominately biomedically-driven, technical solutions that sideline issues of social inequity (ibid.). In line with the adopted neoliberal ideology, in the early 1990s, the responsibility for implementing health care was transferred to Local Government Units (LGUs) through the Philippines' Local Government Code. Devolution transferred functions and responsibilities (services, personnel, assets and liabilities) of all health,

education, agriculture and social service to cities, provinces and municipalities and aimed to “empower” LGUs (ibid.). In a devolved structure, the DOH serves as the lead governing agency in health, with both local LGUs and the private sector providing services to the population (Paterno 2013). LGUs were tasked with financing a portion of their activities, supplemented with DOH expenditure.

However, to a large extent, devolution was poorly implemented (Bossert, Beauvais et al. 2000) and resulted in a fragmentation of administrative services between hospitals and Rural Health Units (RHUs); confusion over who was mandated with specific responsibilities; and limited improvement in actual service delivery (Bossert, Beauvais et al. 2000; Espino, Beltran et al. 2004). A number of subsequent reforms have been introduced that aim to address some of the shortfalls of devolution by improving the way health care is delivered, regulated and financed through systemic reforms in public health, the hospital system, local health, health regulation and health financing (Romualdez Jr, dela Rosa et al. 2011). Most notably, the Health Sector Reform Agenda was introduced in 1999 and more recently, FOURmula ONE for Health was introduced in 2005 as a means to further implement reform strategies (ibid.).

Consequently, international trends and national reform has created a currently devolved system of healthcare in the Philippines through which malaria programmes are structured. This has been coupled with global trends in the rhetoric around how malaria is tackled as well as the fluctuating rates of malaria. Together, these factors have shaped the formation and aims of various malaria projects. The last few decades have seen changes in the goals of international programmes, going through periods of control, de-control, eradication and elimination which propagate a view that malaria is something that can be ‘overcome’. Multiple authors have documented how groups involved in malaria control, including those in the fields of medicine, academia, politics and philanthropy; continue to use language which is infused with military metaphor to describe both malaria and the attempts to deal with it (Brown and Inhorn 1997; Kelly and Beisel 2011). In particular, the current discourse around malaria still retains many of the military metaphors that were particularly prevalent in the post-war eradication era (Brown 1997). Reference is still made to the ‘wars’, ‘battles’ and ‘campaigns’ being ‘fought’ with the use of ‘strategies’, ‘weapons’, ‘tools’ and even ‘silver bullets’, in the attempt to ‘combat’ or ‘defeat’ malaria. However, a combination of the failure of early

eradication campaigns and the reduction in malaria over the last decade, have resulted in changes to the semantic field which has moved on to a more positive framework, frequently including concepts such as ‘sustaining the gains, ‘making durable progress’, ‘shrinking the malaria map, ‘maintaining progress’ etc. While the discourse related to malaria may have moved on from purely military symbolism, implicit in all of these depictions is the idea that malaria is an ‘enemy’, that can be ‘monitored’, ‘controlled’, ‘eliminated’ or even ‘eradicated’. As a consequence, malaria is often framed as a problem which can be ‘overcome’ using a *complicated mix* of standardised technical solutions (Chandler, Beisel et al. 2014).

In the Philippines, the increase in national malaria rates following World War II (Ejercito, Hess et al. 1954), led to the establishment of a nationwide malaria control programme in 1953. The aim was to develop a curriculum that the Philippine government could take over and maintain until elimination was achieved. However, decentralization of the Philippines Bureau of Health (now the Department of Health), the integration of malaria control into the general health service and financial difficulties meant financial support for the programme was not sustained and the annual incidence of malaria increased between 1960 and 1965 (APMEN 2012). Future external support from the World Health Organization (WHO) and the United States Agency for International Development (USAID) heralded in the Malaria Eradication Act in 1966, which recentralised malaria programmes again under the Malaria Eradication Service. However, when external funding ended in 1973, the government was again, unable to sustain pre-1973 gains (Espino, Beltran et al. 2004). Vertical programmes continued until 1983 when they were decentralized again, and, owing to rising malaria rates, redefined their goals as malaria control; the abandonment of eradication mirroring policy shifts elsewhere in the world. As described above, the late 80s and early 90s saw a change in the bureaucratic structure of the Philippine government. Accordingly, a semi-vertical malaria programme was implemented to help tackle the 86,200 malaria cases and 913 malaria-related deaths that were reported in 1990 (APMEN 2012). These efforts successfully halved the number of malaria cases between 1992 and 1996, from 95,778 cases to 40,545 cases (APMEN 2012). In terms of current NMCP goals, eliminating malaria is once again on the agenda. In 2007, the Department of health launched the disease-elimination zone initiative, setting aside specific funds

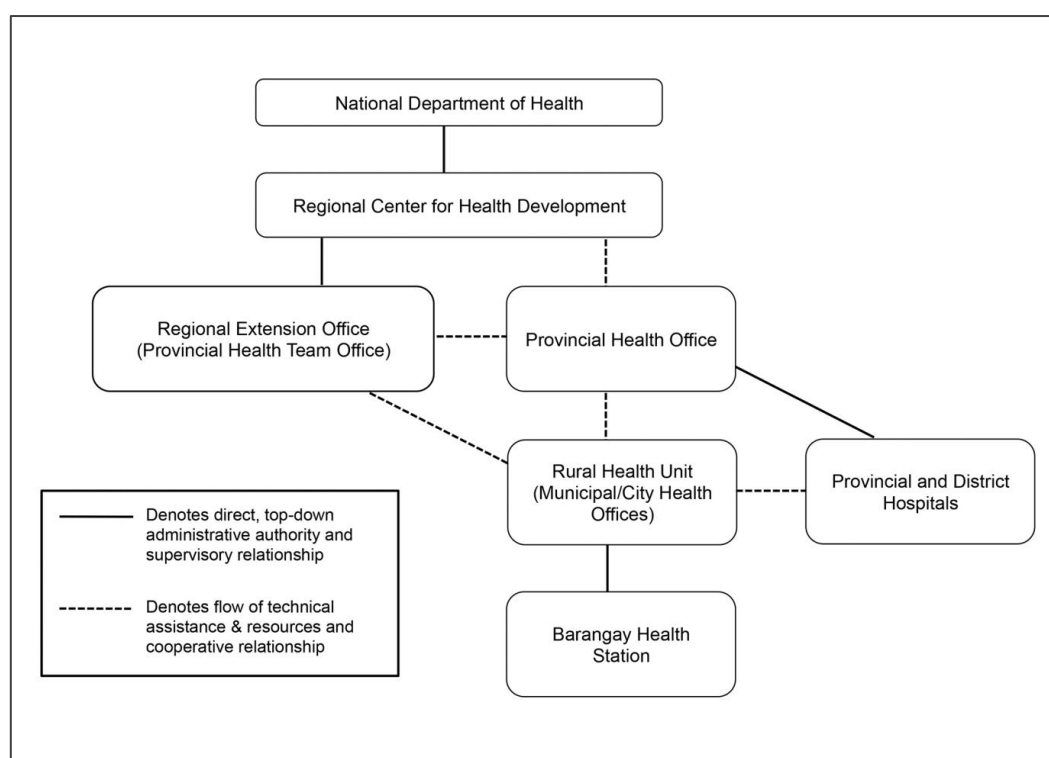
(169 million Pesos/ USD 3.8 million) for this purpose (DOH 2011). In 2009, the Philippines joined the Asia Pacific Malaria Elimination Network and in the most recent Malaria Medium Term Development Plan (2011-2016) from the DOH, reiterated its current aim to achieve a Malaria-Free Philippines but dropped the stipulation that this would be by 2020 because areas like Palawan, Tawi-Tawi, Sulu, Zambales and Mindoro Occidental still have *barangays* with stable transmission and a high number of cases (> 1000 cases) (ibid.).

One of the biggest drivers of malaria programmes is undoubtedly the funding available and much of this has come from sources external to the government. In Palawan, the current malaria-related activities are largely financed through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) but local governments are also expected to fund a small proportion of activities from provincial and municipal budgets. GFATM support in the Philippines began in 2002 when USD 40 million was awarded to two non-profit organisations - the Tropical Disease Foundation and the Pilipinas Shell Foundation (the social arm of Shell companies in the Philippines). Subsequent funding was awarded and by 2010, all existing GFATM malaria grants were consolidated into a single grant covering 40 malaria-endemic provinces including Palawan. The total current funding for the country has reached USD 82,260,754 meaning that the Philippines is largely dependent on funding from external sources for malaria control. This is particularly significant as the GFATM investment may come to an end in 2014 due to the revised grant allocation criteria, leaving the national and local government theoretically responsible for financing and delivering all malaria programmes once again.

The current funding and delivery of malaria services is therefore shared between the national and local government, private health providers and external agencies like the GFATM. The national government, through the DOH, sets policies, standards and guidelines for malaria programmes. It also provides technical training, augments the logistics requirements of the LGUs for anti-malaria services, establishes and operates quality assurance for microscopy, treatment and vector control measures, designs health promotion materials and conducts regular monitoring and evaluation. The DOH operates through Regional Centers for Health Development (CHD), under which sit Provincial Health Offices where DOH representatives are positioned (as well as in

Regional Extension Offices) (see Figure 4.1). Provincial staff provide information, training and technical assistance to the municipal and *barangay* levels (Liu, Newby et al. 2013). The Provincial Health Office is also the recipient of external funding like that from the Global Fund which supplements the limited funding made available from the national and local governments. Within each municipality, a Local Health Board (Chaired by the Vice-Mayor), provides advice regarding annual budgetary allocations to the municipal council. At the lowest level, Rural Health Units and *Barangay* Health Stations implement and deliver malaria control activities.

**Figure 4.1 Diagram showing Philippines health system organization. Source: Liu, Newby et al., (2013).**



### 4.3 The Malaria Control Programme in Bataraza

Although efforts to eliminate (what is biomedically defined as) malaria have been successful in some parts of the Philippines, there are still pockets of transmission. Transmission in the province of Palawan remains stable so current efforts are aimed at both control and elimination. As described above, implementation of the national government's Malaria Control Programme and the responsibility for managing and partially funding malaria programmes now lies with municipal governments through a range of government-funded health care provisions. The Philippine health system also

has a very large, highly unregulated private sector. In Bataraza there is one private hospital in Rio Tuba which was established by the Rio Tuba Nickel Foundation as part of their corporate social responsibility activities. However, only employees of the mining company are eligible for free treatment at the hospital. The nearest government hospital to Bataraza is in the neighbouring principality of Brookes Point and, as such, the government-run Rural Health Unit (RHU) is the main provider of formal care within Bataraza, focussing mainly on providing preventative care along with the 22 *barangay* Health Stations (BHS).

In terms of external funding and support, the Pilipinas Shell Foundation (PSFI) has worked in cooperation with the provincial arm, the Kilusan Ligtas Malaria (KLM) to implement malaria programmes across Palawan. In 2010, PSFI received USD 31.4 million for 2 years and then a further USD 23.8 million to cover the period from 2012 until December 2014. In Bataraza, financial support from KLM makes up 80% of the total spending on malaria activities. The other 20% is met by the municipal and *barangay* budgets. Each month, it is the responsibility of the Medical Technician who is also the Coordinator of vector borne diseases at the RHU to compute expenditure on malaria-related activities for the Local Health Board which, in turn, advises the municipal council regarding its allocations for public health activities including malaria.

In terms of activities, KLM has been providing free long-lasting insecticidal nets (LLINs) in Bataraza since 2004 and these are distributed through the RHU and BHSs. Twice a year, BHSs will announce a specific day for distribution and household heads or mothers are required to come to the BHS to collect their net. Net distribution is usually done at the end of the rainy season between December and March. Between 2004 and 2009, one annual cycle of indoor residual spraying (IRS) was conducted but since 2010, this has gone up to 2 cycles per year in February and August, during the rainy season. Through the Center for Health Development, microstratification of *barangays* in endemic areas has taken place and IRS only conducted in those that have active malaria (i.e. where there has been at least one case in the last year). IRS is mainly funded by central funds held in the Provincial Health Office and PSFI/KLM but as the Medical Technician/Coordinator of vector borne diseases explained to me, contributions are also made by the municipal government and *barangay* councils:

‘Two years ago [the municipality] paid for the incentives of the spray men and for their food and transport. Also the *barangays* were giving something small. The Centre for Health and Development in the Department of Health and the Pilipinas Shell Foundation are now paying for the incentives. The *barangays* pay for food and the municipality pays for transportation so we share the expenses that we have’

In terms of diagnosis and treatment, PSFI/KLM fund microscopists in all *barangays* as well as a limited number of Rapid Diagnostic Test (RDT) technicians. All but one of the *barangays* in Bataraza currently have a microscopist but RDT personnel are only assigned to those *barangays* that have the highest rates of malaria. There are currently 8 trained RDT personnel in the whole municipality and both the *barangays* I worked in, Inogbong and Bonbono, had one assigned RDT specialist. All anti-malarial drugs are provided for free at the point of care and are funded by the GFATM through PSFI/KLM.

PSFI/KLM currently also funds one Community Relation Officer (CRO) in each of the 18 municipalities in Palawan including Bataraza. The role of the CRO is to implement malaria control activities in conjunction with the RHU. In the next section, I will describe some of the practices of various health leaders responsible for delivering programmes so as to situate the discussion within the local context of the Bataraza. In doing so, I show how the malarias of leaders are not simply united in that they are examples of unified ‘biomedical’ enactments. Rather, similarities emerge as these malarias align with shared strategic practices of governance.

#### **4.4 Malarias of governance**

In order to best understand the current National Malaria Control Programme (NMCP), it must be viewed as an assemblage of players, structures and subsystems at different levels that are linked through various processes (Espino, Beltran et al. 2004: 155). Although devolution of the malaria programmes was launched in 1993, the process and timeline for transferring duties varied across provinces (Liu, Newby et al. 2013). The success of programmes rests largely on the commitment and capacity of local health staff to take on and commit financing of activities as well as their understanding of management issues (Espino, Beltran et al. 2004).

A major factor in building support for malaria control and communicating management issues at a municipal level is the role played by the Municipal Health Officer (MHO), who



is responsible for briefing political figures on health matters and formulating policies at the municipal level that conform to national policies (Espino, Beltran et al. 2004). In Bataraza, the current MHO (and only doctor in the area) is regularly away conducting medical missions and training so, in her absence, the Medical Technician (MT) who is also the Coordinator of vector borne diseases is often left as acting MHO. Thus, the MT is the person largely responsible for delivering malaria programmes on the ground and plays the biggest role in communicating and negotiating with government officials.

Both the MHO and the MT reported to me that despite having a number of other responsibilities, malaria control takes up the vast majority of their time and effort and malaria is something that they often describe as a major health 'priority' in Bataraza, particularly amongst indigenous communities. Both these actors have been in post for many years and have spent large amounts of time with indigenous communities who are the target of the majority of malaria control efforts. In particular, the MT has spent years living in remote communities as a gatekeeper and research assistant to the few researchers that have visited the area. As a result, he was also very aware of what he describes as many more 'urgent' health problems in these communities including issues relating to basic hygiene and poverty as well as infectious diseases like diarrhoea, cholera and tuberculosis. Accordingly, he acknowledges the 'over-emphasis' he feels is put on malaria for reasons described in more detail below.

Both the MHO and MT have been trained in biomedical traditions in government institutions in Manila and therefore describe malaria in line with globally common definitions: a biological disease that comprises three main parts - parasites, mosquitoes and humans. The majority of our interviews about malaria-related activities included reference to one or more of these components and revolved around technical solutions that they reported they used to help 'tackle' each of these. These include the provision of efficient diagnosis (microscopy and RDTs) and drugs to target the parasite, house spraying and nets to tackle the vector and education campaigns to increase people's 'knowledge'. It is within this framework that much of these actors' efforts to lobby local government leaders are also couched and the main focus of discussions that I observed with local politicians at Local Health Board meetings. However, as practised health professionals, both these leaders also have direct experience of difficulties implementing these technical solutions on the ground. Consequently, they are acutely

aware of the wider structural factors that they feel also impact health as well as the limitations of the implementation of neutral solutions in far from neutral 'real-life' situations. They often discussed these issues with me outside of formal meetings and interviews about 'official' malaria control activities.

Additionally, as described in more detail below, one of the major strategies that health professionals like the MHO and MT emphasise for malaria control, is the implementation of education campaigns within indigenous communities. These campaigns are aimed at 'educating' people regarding biomedical understandings of a range of health problems. However, despite these articulations within the context of education programmes, the way in which leaders themselves talk about and enact malaria outside of these contexts is not as a single, homogenised conception that necessarily aligns with one 'system' of knowledge. Rather, the malarias of leaders intertwine with more wide-ranging ideas that even sometimes run counter to biomedicine. This is especially so as both the MHO and MT have understandings and experiences of health that go beyond biomedicine and align more with local conceptions of health (such as those described in the next two chapters) as well as their own personal experiences with malaria. For example, the MT reported that because of what he had witnessed over the years, he had been exposed to many 'alternative' understandings of health, malaria and malaria-related practices and had even appropriated some of these realities himself. For example, he told me of how he had regularly seen traditional healers using medicinal plants to successfully treat malaria in local communities and believed that these practitioners possessed effective knowledge and skills outside realms of biomedicine.

As such, the 'biomedical' malarias of health leaders who are largely responsible for implementing 'official' malaria control, are not singularised, neutral or even strictly 'biomedical' at all. Instead they are multiple and draw on many repertoires (a point that is further demonstrated in the next two chapters). Despite these apparent 'contradictions', the malarias of governance are united in that they are pushed forward as a top 'priority' and framed as ones that can be both 'eliminated' and 'educated about'. Following Parker and Allen (2014), I suggest that the motivations for this 'cognitive dissonance' are largely strategic and need to be examined within the wider political and economic setting in which leaders like the MHO and MT operate. In these contexts, such

discourses are important tools in allowing health staff to strategically promote their own vested interests (ibid.).

One of the most important factors affecting the enactment of malarias of governance is the issue of financing since, as described above, at the time I conducted fieldwork, financial support from the GFATM was due to soon end. At the time, the Philippines lacked a long-term, sustainable domestic strategy to finance activities like IRS and net distribution in the 40 provinces supported by the GFATM (UCSF 2012). In fact, recent government data suggest that domestic malaria financing is targeted towards the malaria-free provinces, leaving the current GFATM-supported provinces like Palawan at real risk of disinvestment and resurgence.

This situation makes the uncertainty about the continuation of GFATM money a real worry for health staff, particularly the MT as he feels he does not have all of the information necessary to make adequate plans for the future:

‘Yes I am worried . . . We are in the transition period now so we have a lot of meetings . . . so what we are doing is the allocations . . . of the commodities that the Global Fund has given to us until 2014. If we can supplement this from the LGU [Local Government Unit] and from the PHO [Provincial Health Office] then it’s ok so we are doing our best now to gain support from the LGU and PHO . . . Hopefully there will be another funding programme that can renew the funding because we don’t have any idea now if they will continue the funding or stop in 2014. What we know here is that the Global Fund will end in 2014 but there are some meetings at the upper level and they are still trying to convince the Global Fund to continue their support for TB, malaria and HIV’

While staff are certainly motivated to meet targets by their genuine concern over malaria and the people it afflicts, the fact that proportionally more funding is available for malaria-specific activities from various sources when compared to other diseases, also means that raising funds, conducting activities and delivering success in this area is also a necessary means for senior staff like the MHO and MT to secure a salary, progress in their careers and build their own reputations. As such, malaria provides a useful tool

for them to for them to garner economic and political will that ultimately benefits them in ways somewhat unconnected to malaria.

Similar pressure is also put on staff lower down the chain to try and meet targets for malaria control in order to demonstrate success and secure their own careers. Many health professionals that I spoke to were dubious about the possibility of reaching targets for malaria control. Nevertheless, they have to continue with the drive to implement top-down programmes. As described above, the Malaria Medium Term Development Plan (2011-2016) from the DOH has dropped the goal to eliminate within a specific timeframe but this message has not filtered down to local health staff who are very much still focussed on the aim to eliminate malaria completely from Bataraza by 2020. As the husband of one BHW told me:

‘In the RHU or even the BHWs, if they see even one case of malaria then they will get disappointed. Even my wife, because of the command of her superior, she is also so upset when people arrive in the house and get [one] positive [result] for malaria then she is disappointed. They are very determined to be successful in their jobs and make zero malaria’

For many health professionals, the emphasis on malaria can be to the detriment of other health and wider social problems that they feel also require attention and investment. The BHWs husband continues:

‘Me: Is there as much focus on other diseases?’

Participant: Generally speaking no. There is a, how shall I say, *out* of focus. Other kinds of diseases are out of focus. Number 2, the budget just focuses on malaria but how about all the other diseases?’

This view was shared by the majority of health professionals that I spoke to, including senior ones like the MHO and MT as mentioned above. They recognise that more focus is put on malaria due to the existence of so many programmes and the emphasis on elimination and are conscious that other health and social problems are a more urgent problem, especially for those who are most marginalised in society who are the target and recipient of many of these interventions; as this discussion with a malaria microscopist reveals:

‘Me: Do you think malaria still a big problem here?

Participant: Yes! [emphatically]

Me: If the cases are so low why do you consider it is still such a problem?

Participant: Because we have a target to get to zero malaria but in 2012 Bataraza was 2<sup>nd</sup> [in terms of highest cases] in the whole of Palawan. In a month, in the official record they might have more typhoid cases . . . more than malaria. But we have so many malaria programmes and targets that more emphasis is put on that. We have net distribution and spraying. As long as there are any positive cases then it still [considered] a problem. If they have even one case then it can spread and so it puts everyone at risk so even one case is still a problem.

Me: Are there any other health programmes/initiatives apart from malaria?

Participant: [Shakes head] No, not the same.

Emphasis on meeting malaria targets and delivering malaria programmes is particularly acute around election time, when health officials at all levels feel that a lot of their time is diverted to building support for continued investment for malaria political parties. Throughout the election campaigns that I witnessed, malaria was used as an important political tool for health staff to both demonstrate success and garner more support from local politicians. Awareness campaigns for malaria were intensified and positive results regularly broadcast, helping to make the case for continued investment in the health sector and its staff.

A related, and perhaps more potent problem around election time, is the increasing politicization of health staff appointments, at both a municipal and *barangay* level which affects both staffs’ ability to carry out their duties and security over their appointments. Casual workers at the Rural Health Unit (RHU) and *Barangay* Health Workers (BHWs) told me that they are selected based on their political allegiance, particularly at a *barangay* level, putting them in an insecure position in the lead up to and following elections. BHWs in particular, often have their efforts diverted for local political operations on the ground such as campaigning, leaving them less time to conduct their

health duties. Job insecurity due to political allegiance is a real source of anxiety for many workers who value their roles in communities and also rely on the small income they get from these roles but who are also concerned for their own safety and that of their families. For example, one BHW told me she felt very scared in the lead up to the election because she supported the opposition candidate. She was nervous when she was conducting her duties, avoiding some households and areas despite knowing that those households might need medical attention and was careful about who she discussed politics with in case the Mayor's 'men' were 'watching her'. Following the election of Mayor Ibba's wife, she lost her job, and although given no explanation, was sure that it was for political reasons. For staff on a permanent contract, the situation is slightly better; however, those like MT do also worry about being 'watched' or 'listened to' and spend time campaigning on behalf of their staff who they have invested time in selecting and training:

'What we are doing, me and [the Community Relation Officer], we do our best to talk to all the *barangay* captains and to the mayors about this. But, they have their own records and they have their own eyes'

As well as being impacted on by local political affairs, health issues also intertwined with broader narratives relating to economic development in Bataraza – most notably those around tourism and mining. In the local political structure, the most important figure is the Mayor who has supervision and control over all health programmes, projects and services (Espino, Beltran et al. 2004). According to health staff, Mayor Ibba (in post until May 2014) is very supportive of malaria control initiatives and staff were hopeful that his wife Katherine (elected to the post in May 2014) would carry on this legacy of support. Mayor Ibba himself told me how President Aquino's health policies were his 'top priority' and that he uses personal money to fund vehicles, boats and accommodation for staff from the Rural Health Unit to aid them on their medical missions to remote areas as he was very keen to see malaria eliminated entirely from his municipality. Similarly, many *Barangay* Captains are described by health staff as being supportive of funding malaria control activities in their constituencies and similarly expressed their support of such initiatives. As discussed further below, while some of these local leaders are no doubt well-meaning, their support for malaria

programmes and the emphasis put on elimination, has other political and economic motivations.

In the case of tourism, the construction of an airport was planned in the near future just north of Bataraza, in the neighbouring municipality of Brookes Point, in order to increase the economic contribution of tourism to the local economy. The Mayor told me that he planned to turn Bataraza into the 'tourist capital of the South' and attract 'more foreigners like [myself]' to the area. However, the reputation of Palawan, particularly southern Palawan, as the 'malaria capital' (Ramos 2013) of the Philippines presented an obstacle to these attempts. Consequently, the mayor's motivations for investing in malaria elimination, as in many other global contexts, were also deeply tied to his economic ambitions for the area.

As described in chapter 2, nickel mining and processing has also become prolific in Bataraza with the Rio Tuba Nickel Mining Corporation and Coral Bay Nickel Corporation conducting large-scale extraction of nickel from low-grade ores. The majority of local people, including health staff, reported that the recent increase of a number of health conditions including respiratory infections, vector-borne diseases such as malaria and dengue, skin conditions and accidents were as a direct result of mining. In tacit recognition of this relationship, 11 of the 22 *barangays* in Bataraza receive financial support and investment in health from the Corporation through their corporate social responsibility activities. As such, *Barangay* Captains in receipt of this support (as well as the Mayor) are under pressure to exhibit success in malaria control and meet elimination targets in order to demonstrate the success of the Corporation's activities as well as help to lessen the negative consequences of mining in their area. Paradoxically however, many *Barangay* Captains that currently receive funding from the Corporation, simultaneously underplayed the negative effects of mining activities in their *barangays* in interviews which, according to health staff is in order to curry favour with Corporations and ensure their continued financial support and investment in their areas (as well the rumoured continuation of personal bribes to Captains). Health staff feel that the effect of mining on the health of the population, the quality of air and water and environmental damage wreaked as a result of mining activities cannot be restricted to just the 11 *barangays* currently offered support and lobby for investment across the whole of Bataraza. However, they too reported sometimes feeling under pressure to

underplay the effects of mining in 'official' meetings and circles for fear of losing financial investment, their jobs and even their lives.

The influence and reach of mining companies extends to control over research that is done in the area including my own. As described in chapter 3, I was required to gain a number of approvals to conduct my study as it involved research with Indigenous Peoples (IP). On an initial scoping visit to Bataraza in April 2013, I visited the Rio Tuba Nickel Foundation Inc., the social development arm of the Rio Tuba Nickel Mining Company and Coral Bay Nickel Mining Corporation. In a meeting with the Executive Director of the Foundation, I was told in no uncertain terms that I was unwelcome to conduct my study with IP communities who were beneficiaries of the Foundation's social programmes if my objective was to 'investigate people's views about the health effects of mining companies' in order to 'mobilize them to raise up their voices in protest'.

Narratives about malaria also intertwine with those that relate to wider neoliberal economic 'development' of indigenous populations which emphasise the central role of 'education'. As described above, funding from PSFI/KLM includes the provision of a Community Relation Officer (CRO). One of the principal functions of this post is to hold regular Information Education Campaigns (IEC) within communities that have reported at least one malaria case the previous month. In Bataraza, the CRO works in close collaboration with the MT at the RHU and they conduct IECs in local communities together. These activities are often combined with 'medical missions' which include activities like mass screening for malaria, net distribution and other routine health campaigns like sputum collection, nutrition advice and dental care. IECs take the form of an hour presentation by the two health staff that goes through the symptoms and causes of various febrile illnesses including malaria, dengue, typhoid and urinary tract infections. This is combined with information about mosquito biting times and net use. IEC staff also discuss other diseases like Hepatitis A, B and E and sexually transmitted diseases. When staff conduct these sessions in schools, they often end with a quiz for children. The RHU also broadcasts a weekly radio programme on a local radio station in which they disseminate similar information.



Implicit in these education programmes is the idea that knowledge that diverges from a biomedical understanding of disease is one of the main barriers to what is deemed 'appropriate behaviour'. As a result, although many health professionals recognise the multiplicity of disease and even hold many views themselves about malaria that run contrary to 'biomedicine', emphasis is nevertheless placed on delivering 'biomedically' grounded education, as shown in the following quotes from various health professionals.

Me: 'What is the biggest barrier for malaria control in these areas that I have been visiting?'

Participant: 'Wrong information. Because sometimes the IPs [Indigenous Peoples], the beliefs that they inherited from their ancestors is still intact. Like when you drink coconut water you get malaria. And the 'quack' doctors. When the person gets sick even when you teach them to go to the Health Centre they still go to the quack doctor . . . The IPs have behavioural problems. . . Even when I will conduct IECs [Information Education Campaigns] they don't listen. If you go there they say 'yes we understand' and then when we come back again they say 'no we don't'

*Community Relation Officer*

'Malaria is really a significant problem in those areas because of the attitude of most of our IPs [Indigenous Peoples]. They are the ones who are really affected. We still cannot change their practices and beliefs towards the treatment and compliance of malaria and the compliance of using bed nets and the IRS [Indoor Residual Spraying]. We are also having problems with them being nomadic as they tend to transfer from one place to another. So I think we could not eradicate malaria because of them. That's our problem'

*Medical Technician/Coordinator of vector borne diseases*

'Health is not a primary concern for IPs [Indigenous Peoples] as they have a very day-to-day way of living and their lives revolve around getting food for one day. They work until they have enough food for the day and then stop . . . Like diarrhoea and hygiene. The majority of cases

relate to diarrhoea because they have very different beliefs in waste disposal and hand washing. In one [area], the company built them a toilet but they didn't use it. If you see some of the IP patients, you can tell by looking at them that they have very different hygiene practices. It is not their primary concern. For them it is food. Only food'

*Doctor*

'IPs [Indigenous people] don't use their nets and they don't take all their prescribed medicine. Their belief is to stop when they feel better and store the rest in their ceiling [rafters]'

*Barangay Health Worker*

This emphasis on education results in a discourse that equates risk factors for disease with individual identity and ethnicity as *cultural* 'beliefs' and 'practices' that do not align with *correct* biomedical 'knowledge' and 'behaviour' are viewed as the root cause of unequal distributions of disease. A dichotomy is therefore created between those who are 'civilized' and thus 'educated' and 'knowledgeable' about malaria and those who are not and thus 'uneducated' and 'unknowing'. Consequently, malaria is also used as a political tool to drive 'development' in indigenous communities. The Community Relation Officer referred to this process directly as one of 'civilising the natives' and bringing their standards up to 'modern' conditions. This is most overtly manifested in the stratification of *sitios* (villages) by the PSFI/KLM malaria control programme in terms of how 'civilised' they are as the Community Relation Officer explains:

'The programme stratifies *sitios*. [They are categorized as civilised] if there is a leader, a chieftain who I can coordinate with - because some of them cannot understand how to talk to Tagalog because their language is still native . . . Also [they are categorized as civilised] if the young people are no longer going down - like they don't still have nomadic behaviour. . . Also if there is no longer the problem of going to medicine man . . . and if they are no longer getting married so young'

As a result, control efforts aimed at education are also supported and reinforced by wider neoliberal views of economic development which is framed within rhetoric of ideas like progress, growth and good governance.

#### **4.4 Conclusion**

In this chapter, I have documented how 'biomedical' malarias are actively produced and reproduced but also contested and negotiated by the practices of various local health professionals. The pressure of top-down health targets, electoral campaigning, tourism, the mining industry and concepts of cultural and economic development are central to the way in which certain malarias are enacted by these leaders within the context of governance. In Bataraza, the increasing politicisation of malaria has created a situation in which health professionals enact malarias that are a 'priority', can be 'eliminated' using predominantly technical solutions and can be 'educated' about. Although these articulations and enactments intertwine with leaders' own alternative understandings and practices related to health as well those of healers and patients who are the targets and recipients of many programmes (as discussed in the next two chapters), these alternative and multiple malarias can become silenced, ignored and often neglected (Kelly and Beisel 2011) within the context of 'official' programmes as leaders use hegemonic discourse as a tool (Parker and Allen 2014) to push forward with their own strategically motivated goals.

## Chapter 5: The malarias of professionals

In this chapter, I turn my focus to some of the healers who are largely responsible for diagnosing and treating illnesses including malaria in Bataraza. I show how healers, even those from the same 'systems' or 'traditions', do not necessarily share particular 'perceptions' of what malaria is, nor are they necessarily united in what they do to diagnose or treat it. Rather, like leaders, they too enact multiple kinds of malaria and practices, some shared with other healers, some not. These enacted malarias nevertheless also hang (Mol 2002) together in certain ways because, despite their variation, they are enacted alongside shared practices of professionalization. Within the field of healing, professionals distinguish themselves from their patients through the enactment of specific training and expertise as well as the use of specialised instruments. In turn, these practices mean that similar kinds of malaria are enacted. The malarias of professionals: require trained specialists to deal with them; although multiple in nature, are all objectified entities (described as 'things', 'dirt' or 'parasites') 'hidden' inside bodies that need to be 'uncovered' or 'seen'; and require the use of specific instruments to both find and treat them.

### 5.1 Healers in Bataraza

Before discussing particular practices, it is important to give a more general account of the wider therapeutic landscape of Bataraza in which professionals are situated. I use the term 'therapeutic landscape' to describe 'zone[s] of experience and meaning' (Wilson 2003: 84) where multiple therapeutic possibilities are available, experienced, understood and enacted through practice by the population that live with them (Leach, Fairhead et al. 2008; Hampshire, Porter et al. 2011). There is still a tendency in much of health-related work to make distinctions between 'types' of 'system' or 'traditions' so that different elements are pitted against each other like biomedical and folk; modern and traditional; formal and informal and public and private. This creates an illusion that ontological differences between various categories (e.g. biomedical and folk) neatly map onto essential differences in both beliefs and practice.

For example, some recent literature regarding health care in the Philippines suggests that government expenditure on 'formal health care' constitutes 3.5% of Gross Domestic Product (GDP) (less than the World Health Organisation's recommendation) (Kadetz

2009) while the 'informal sector' contributes to more than 40% of GDP and plays a more significant role in creating employment, producing goods and services, and augmenting income (Mendoza 2009: 334). In many areas of the country, 'informal' medical practitioners continue to be the main providers of health care (Tan 2008) and according to the Department of Health, there is one 'informal' health practitioner for every 300 Filipinos. In contrast, the ratio of 'formal' doctors is considerably lower at 1 to more than 26,000 (Mendoza 2009:334). The 'informal sector' is said to be based on the use of a particular knowledge and practice system - traditional, complementary and alternative medicine (TM/CAM) and this is widespread in both primary and secondary health care settings (Mendoza 2009). Conversely, the knowledge and practices aligned with 'biomedicine' constitute the basis for much 'formal' care (WHO/DOH 2012).

The implication of this typologising is that knowledge, and more significantly, practice around a particular disease is subsumed as a product of a system rather than given an instrumental part in *enacting* both the system and the disease itself. This is despite much anthropological work which has highlighted how these approaches ignore the syncretism that exists within systems; the ability that actors have in transcending boundaries (Marsland 2007); and the role that power and symbolism have in reinforcing divisions (Brodwin 1996) and allowing some systems to 'dominate', 'colonize' or even 'co-opt' other traditions for their own endeavours (Hampshire and Owusu 2013). While these ideas are not new to medical anthropology, they are yet to pervade the arena of public health and development to the same extent and ideas of bounded health systems still persist.

In recognition of critiques of this kind of rhetoric, I *begin* with practices in order to show that they are not the *product* of clearly bounded internally coherent 'systems' (Last 1981). Conversely, differences between systems, rather than being innate, are in fact performed and rooted in practice (Pool 1994). Through embodied practice, actors engage in a continual process of inter-subjectively *enacting* boundaries that are, by their constructed nature, contingent, fluid, transcendable and even sometimes illusory. Starting with what people do, helps to reveal not only what these boundaries are at different times and in particular spaces but more importantly, the specific circumstances under which and the reasons *why* they are enacted and for what ends.

I begin my discussion by describing the practices of two healers from the ‘informal’ sector that come under the generalist categories of *albularyo* (Tagalog for herbalist). The number of *albularyos* is hard to estimate, since many offer occasional services, some operate in secret and others only treat certain patients (e.g. family/group members). In the course of my fieldwork, I came across two major forms of *albularyo* that fall under the more specific categories of *balyans* (Palawano for healer) and *manghihilots* (Tagalog for therapist). Both are united in their use of various herbal-based remedies which characterises all *albularyos* as well as their special relationship with unseen spirits. However, there are some distinctions between them as *balyan* are specifically from the Palawan community and rely on visualisations and invocations of spirits during the healing practices whilst *manghihilots* are widespread amongst the whole of the Philippines and employ massage as the main basis of their treatment.

As well as *albularyos*, the population of Bataraza is also served by health care options that fall within the ‘formal’ health sector. The Rural Health Unit, in the centre of Bataraza, is the provider of primary care and some acute treatment. The RHU employs the only doctor in Bataraza, a dentist, two nurses, two midwives, a microscopist and a medical technician. As there is only one doctor for a population of over 60,000, most patients coming to the RHU will not be able to consult the doctor. On a more accessible level, each of the 22 *barangays* has a *Barangay* Health Station (BHS) which employs midwives, microscopists, sanitary inspectors and nutritional specialists (usually one to two of each of these personnel). In some *barangays*, a trained specialist in malaria Rapid Diagnostic Tests is also employed. In addition, each BHS also has a number of voluntary *Barangay* Health Workers (BHWs) who operate within the community and as such provide an instrumental role in providing primary health care to the population in areas such as hygiene and sanitation, infectious diseases and maternal, newborn and child health. In terms of the availability of drugs, prescriptions can only be obtained from the Rural Health Unit, which do supply some drugs. Other than that, people usually buy drugs and medicines from a few pharmacies in the town. I lived in the town’s largest pharmacy (with the only licensed pharmacist). However, a number of smaller, mostly unregistered, pharmacies can be found in the main town. I will describe the practices of two healers that work within this ‘formal’ sector – a *Barangay* Health Worker and a pharmacist. The case studies I present here were chosen because their practices are

representative of many healers that I came across. Here, I show how the practices of healers and the malarias that they enact as a result, although in some ways different, are still united, less because of their adherence to particular ontological 'systems' or 'traditions' and more because they are coordinated by an aim that *all* these healers share – the practical establishment of themselves as 'professionals' (Last and Chavunduka 1986) in relation to their patients.

## **5.2 The *Balyan***

Sario is a middle aged man who is from the Palawan ethnic group. He lives with his wife Pina in a small community mainly composed of some of his 23 children from multiple past marriages. Sario comes from a family of Palawan shaman or *balyan* and has therefore acquired some of his knowledge and skills from his relatives and ancestors. Although he wanted to be a practicing *balyan* he had not had a 'calling' to do so. However, one night, the spirit of his dead uncle appeared to him in a dream and instructed him to go to a cemetery and dig a hole and wait in it for seven days and seven nights with no food in order to pray for some kind of 'power'. The first time he did this he was visited by some spirits in his dreams but nothing came of the attempt. He repeated the exercise some months later:

'Wow! So many things happened. I was lying down and snakes were there, so those are like temptations, like a test. On the fifth night, I was starving and yet no answer for my prayers, but on the sixth night I began to hear some strange sounds like the sound of metal jangling and on the seventh night in the morning, early at dawn, there was a small boy in front of me who asked me 'What do you want? Why are you here?' So I said 'I want the ability to heal sick people. I want you to help me'. He said 'OK, wait until tomorrow'. The next day I heard a rushing wind, and then later I saw a big man in front of me who was seven foot wide. . . and he said 'What do you want?'. I said I wanted to become a medicine man, and so the man said 'OK, I'll give you what you want' and he gave me a stone - an *anting-anting* [Palawano for charm]. . . Then, from that time on, I began to have supernatural powers in my life. . . If I am holding the stone and I put it to my ears, I can hear spirits talking, even from the mountains – I can hear what the spirits are saying'

Thanks to these ‘supernatural powers’, Sario is able to diagnose and treat a range of illness. In terms of diagnostics, Sario employs a mixture of visual observation as well as some tools that help him to discover the underlying causes of illness. When he first looks at a patient, if he can see tiny worms coming out of their eyes and smoke coming out of their nose, then he knows they are suffering from sicknesses that are better treated in the health clinic so he instructs patients to go and see a doctor in the town. This is the case for malaria as, according to him, this ‘modern’ disease is caused by ‘things in the body’ that he ‘cannot see’ and therefore cannot treat. Sario has had many patients come to him in recent years who are suffering from what he suspects is malaria. In these cases, Sario sees the signs described above and refers patients on to other specialists.

For those he can treat, Sario will first feel their pulse whilst calling upon the spirits to assist him in his diagnosis. He will also use a *tari-tari*. This diagnostic tool is a bamboo stick with honeybee wax at one end from which a piece of *rocoroco* (*Ocimum sanctum* or Holy basil) is attached. Sario’s *tari-tari* was made by his father (also a *balyan*) and he inherited it from him after his death. The *tari-tari* is the same length as the span of Sario’s hand but it will become longer or shorter to respectively confirm or refute the questions that Sario asks it (see Figure 5.1). Sario will ask each question (for example about the source of the illness or appropriate treatment) three times and has to receive the same answer all three times to ensure the answer is validated.

**Figure 5.1 Photograph showing Sario using his *tari-tari*. Source: Sario.**



Although he reports that he does not treat malaria, Sario does treat a number of ailments that share signs that he says are similar to malaria like fever, malaise, body



pain and headache but that have different causes that he *can* see and therefore treat. For example, one evening a man came to him with fever and feelings of weakness. The patient's father told Sario that he believed his son was suffering from *pintas* (Tagalog for curse or evil words). Sario was able to confirm this was the cause of the man's fever through feeling his pulse. He suspected that the bad words had been spoken by a scorned lover with a 'sharp tongue'. He explains the diagnostic process:

'[I touch] this portion of the wrist [indicates part of the wrist]. if it's *pintas* then it's very hard. If it's this portion then it's a human who caused it. But in this portion [indicating another part of the wrist], if it has a very strong pulse that means they have a sickness from the forest, or mountains or bad spirits'

As a treatment, Sario invited the patient to stay over and gave him a bath at 5 am the next morning in order to 'send the curse back to the person who gave it to him'. He also gave him a *pananga* which is an example of a *panulak* (repellent). This small cloth pouch, which was sewn by Sario's wife Pina, contains seven specific herbal plants and roots, the contents of which were revealed to Sario in a dream. If tied round the waist using string, the *pananga* will reverse the curse and help defend the patient against further attacks.

As well as illnesses caused by human agents, Sario can also diagnose those that are caused by malevolent *diwata* (Palawano for spirits). In order to treat these illnesses, Sario must enter *natutulog* (Tagalog for a sleeping state) in order that his own *kurduwa* (Palawano for soul) leaves his body to be replaced with a *diwata* with whom he can communicate. Sario will adorn a colourful headband that has sprigs of *rocoroco* (*Ocimum sanctum* or Holy basil) tucked into it. The headband allows *diwata* to see Sario and thus locate him. He then closes his eyes and starts to use *tawar* (Palawano for incantations) to invite *diwata* to enter his body. Sario feels himself becoming dizzy as he is entered by a *diwata* and at this point is unable to 'see' what is happening in the human world. Once possessed, Sario can communicate with the *diwata* in his body who can also help him to treat patients. For example, one patient came to him complaining of body pain, particularly in his back. Sario was able to use this diagnostic technique to determine the unseen cause:

‘Some bad *diwata* had gone inside the back of this man to give him body pain. I can’t remember who the *diwata* was because I was sleeping. Sad to say that the *diwata* in the mangroves got angry with this guy because he is always destroying the mangroves and I suspect that the *diwata* in the mangrove stabbed him using their *bolo* [knife] because he is not doing good in their place – maybe he is destroying their place’

In this case, malevolent *diwata* had entered the patient’s body, displacing his own *kurduwa* (soul):

‘When we are walking somewhere our own *kurduwa* are with us, but the other *diwata* have much more numbers than people living here on the entire planet and these unseen *diwata* are able to hold onto [grab hold of] our *kurduwa*, if we do not have the defence, if we do not have protection then these bad *diwata* can enter us’

In order to treat this kind of soul-loss, Sario picks specific *rocoroco* tips which he waves in a circular motion over the patient along with *silad* (pom poms) made from Mangrove Fan Palm (*Licuala spinosa*) accompanied by *tawar* (incantations) to call good *diwata* to his aid (Figure 5.2). As he explains:

‘First, I use the *rocoroco* to remove the ailments like bad *diwata* . . . six times going round [in a circle] with the *rocoroco* . . . Whatever it is that makes the patient sick, it hangs on the *rocoroco*. Then, the seventh time, I will call the man’s *kurduwa* to come back and when it is there, it hangs onto the *rocoroco* so that I can then put it back inside [using the *silad*]. I get the *silad* and do the same – round six times . . . The purpose of the *silad* is that when I am sleeping and holding the *silad*, any person who is suffering some kind of disease comes close to the *silad* then this *silad* will be the one to heal them. There is a superpower in that *silad* – it has a high purpose of curing the disease because my power and the power of other *diwata* are going through that *silad*. Because my eyes are closed I cannot see anything, only the *silad* can see . . . and it will take out the diseases that are there and return the lost *kurduwa* to the patient’

**Figure 5.2 Photographs showing Sario using *rocoroco* and *silad*. Source: Sario.**



Sario is also able to use the *rocoroco* and *silad* to return detached *kurduwa* to patients. For example, a father brought his baby to see Sario after she had fallen in the house was unable to sleep, leaving her with a bad headache, feeling weak and lacking in energy. Sario diagnosed that the fall had caused the baby's *kurduwa* in her head to dislodge and leave her body. He was able to enter a dream state, find her lost *kurduwa* with the help of other *diwata* and return it to the baby using his *rocoroco* and *silad*.

### **5.3 The *manghihilot***

Nicanor is an elderly man who is a member of the Surigaonons ethnic group which is part of the larger Visayan ethnolinguistic group. Although originally from Mindanao, his father was a prisoner in Palawan and, upon his release, relocated his family to Palawan which is how Nicanor came to Bataraza. He now lives in Bataraza with his wife and two grandsons. Nicanor is a renowned *manghihilot* in the area and patients come to him from all over Palawan. By his own admission, he has never had a patient he could not treat except, sadly, himself. For the last few years he has been paralyzed down one side of his body and is now confined mostly to his bed. In the few hours I spent with him, four patients came to see him, some of whom had travelled long distances, and he reported that he usually had a constant stream of people coming to see him most days. I asked Nicanor how he became a *manghihilot*:

'I am a twin. My twin was a snake and when the moon was dark she would take a bath and when she took a bath she would become a woman. She is the one who taught me how to become a *manggagamot* [general Tagalog term for healer] . . . She was long when she came out of

the womb and when we were breastfeeding, I would take one breast and she would take the other but my mother would be out of consciousness because she was so afraid of the snake. She came out as a snake but we were attached by our umbilical cords. We lived together for 20 years. She loved to sleep under the mosquito net and when there were mosquitoes around she would eat them. She lived in a separate room and in the evening time no one would enter her room because, at that time, she was a woman. She could understand words and would nod her head [when we spoke to her] . . . she grew as long as the house and very high. All my cousins would come and ride on her and play with her . . . we would ride on her back and then she would go faster and people would fall off [laughs]. The snake would be eating rice and when it finished its tail would tap meaning 'finished' and then me and my cousins would wash the plates.

Then, one day, we fought about who came out the womb first so I hit her with a stick and she got angry and left. I know she is still alive because we were attached by the umbilical cord so when one of us dies, the other will also die. I said I was the first born but she said 'no'. She said she saved me coming out from the womb. . . When we were young, she would take me to the forest and bite the plants and while she was showing me, she would tap her tail on my forehead and say 'you remember this' so that is how she taught me about being an *albularyo*. I am also a *manghihilot* and I fix bones. She would wrap herself around me and crush all of my bones. Then she would tap me at the neck and all over and the bones would be healed. This is how I learnt how to do that kind of massage'

Although Nicanor gained his knowledge and skills about herbal medicine and massage from his twin sister, he explains that his decision to become a practicing *manghihilot* was really down to his interactions with the spirit world. Many years ago, when his son was sick, a vision of an old man came to him and told him what plant to use to cure his son. Following this experience, he had a dream in which music playing from a mango tree indicated there was a spirit living in the tree. He tried to cut the tree down using a chainsaw but it would not fall down. He then walked around the tree seven times, kicked it and it fell down, stopping the music and killing the spirit. These experiences

confirmed to Nicanor that he had a special 'gift' that allow him to have a relationship with the spirit world. Ultimately, it was this 'calling' that persuaded him to become a *manghihiilot* to 'help the people'.

Now, when a patient enters Nicanor's house, he first looks at the patient, rubs his own hands with oil, holds the hands of the patient in order to feel their pulse and begins whispering a silent prayer to the "Lord". This will invoke visions, 'like a dream', where spirits help to reveal the site and cause of illness as well as the appropriate treatment. While he is praying, he is simultaneously able to talk to patients who sometimes reveal their symptoms or perceived cause of their illness. However, Nicanor does not need to ask his patients questions as he is able to determine their illness and the cause through his own diagnostic measures. Because of his relationship with the spirits, he is able to *see* the cause of illnesses and distinguish between those caused by spirits and those which have involved the actions of human agents.

As well as illnesses caused by spirits and human agents, Nicanor is also able to diagnose sicknesses caused by disequilibrium in the body. This includes malaria which he explains is caused by 'dirt' entering the body from contaminated food or water, restricting 'flow' inside the body. As before, Nicanor rubs oil onto his hands and feels the patient's pulse, makes a prayer to the "Lord" to invoke visions which may help him to see where the malaria is and its cause. He also looks at and feels to see if the person's *baso-baso* (Palawano for abdomen) is swollen and stuck 'with malaria' and observes the patient's lips which, if white, also indicate they have malaria. Roasted and powdered tree bark is mixed with kerosene and massaged into the body as treatment in addition to the healing oil that he makes himself (as described below) in order to expel the malaria and restore the 'flow' of the body. Although Nicanor used to treat many cases of malaria, he now sees less and less of these patients acknowledging that they prefer to go and see the doctor because they have stronger drugs. Consequently, if one of Nicanor's patients comes to him with what he diagnoses as malaria, he gives them his own treatment but also advises them to go to the Rural Health Clinic if they are not better within a couple of days.

In terms of his treatments, as in the case of malaria, Nicanor will administer specific herbal treatments and give massages using healing oil that he makes himself (see Figure

5.3). The healing oil is made from coconuts selected from a tree with only a few fruits that all face the East. Three coconuts have to be gathered by Nicanor himself and cannot be not dropped in the process. The oil from the coconuts is then mixed with 27 kinds of grasses, roots, bark and tree leaves which are all inhabited by various spiritual entities. Nicanor knows which plants are needed because as he walks and prays, the plants he needs move or rustle. Nicanor explained that it is the oil itself which is powerful and not the massage: ‘without the oil, my hands are powerless’. So significant is this concoction, that its exact contents are a secret even from Nicanor’s children.

**Figure 5.3 Photographs showing Nicanor massaging patients using oil. Source: author.**



While Nicanor is protective about the contents of his oil, he told me there were other treatments that he was happy to share his knowledge of. In fact, over the years he has helped in the production of government-licensed tablets made from the plants he knew to be effective:

‘The doctor asked me about remedies for diarrhoea. The herbal medicine I had for that is not bitter and so even the children can tolerate it. I told the doctors and we went to the forest together and I taught them . . This was 7 years ago. The doctor injected in these trees and said ‘yes it’s true’ and then they made tablets from the *sambo* plant’

#### **5.4 The *Barangay* Health Worker (BHW)**

Elyn is in her 40s and is married with five children. Elyn, like her husband, is from the Tagbanua ethnic group which are indigenous to the North of Palawan. The couple moved to Bataraza in 2004 from Aborlan in the North of Palawan and Elyn applied to

become a BHW. This decision was partly motivated by the practical need for her to earn an income but also due to the fact that both her grandfather and her grandfather-in-law were *babalyan* (Tagbanua for shaman). As such, she tells me that she inherited a lot of knowledge of how to heal from both of them including the use of herbal medicines. As my relationship with Elyn developed over many months, she also revealed to me that her grandfather had also given her a 'charm' before he died which conferred healing 'powers' to her. As such, she sees her decision to become a BHW as a 'natural' choice because of this ancestry and describes it as a 'calling'. In recent years, she has also become a malaria Rapid Diagnostic Test (RDT) technician for the *barangay* of Bonobono. For this role, she has undergone specific training about malaria, its diagnosis and treatment. The content of these courses is produced by organisations like the World Health Organisation and is largely biomedical in nature. As such, Elyn explains to me that 'malaria is a disease caused by parasites that enter human blood through the bite of infected female mosquitoes'. In order to be sure someone has malaria, they must be tested using an RDT or through examination of a blood film under a microscope so that the 'malaria can be seen'. In other conversations, Elyn tells me about knowledge of malaria that she has gained, not from her formal BHW training, but from her own experience. For example, according to her, malaria symptoms may not necessarily manifest if you are strong, well-fed and healthy, even if the parasites are in your body. Rather, the likelihood of malaria manifesting is related to sudden changes in weather, hunger or over-fatigue. This is the knowledge she gained from her ancestors as well as from her own personal observations and experience.

The malaria-specific training Elyn received as an RDT technician, is in addition to the basic training she had to become a BHW. Each BHW undergoes a basic training program under an accredited government or non-government organization and are then eligible to attend on-going seminars and courses throughout their career. Again, the majority of the content of these courses is biomedical in nature but there is also some instruction given regarding the use of government-approved herbal medicines. Elyn continues her training by attending seminars or training courses once or twice a year. She is extremely proud of this and always willing to attend more seminars; however, her attendance largely depends on her ability to pay for her transport to and from the courses, even those located in the town of Bataraza. The position is voluntary and BHWs receive only

a modest monthly honorarium of 1,000 Pesos (£10) a month. During my time in the field, this went up to 1,500 Pesos (£15).

The number of BHWs at each health station depends on the population. Although stations are mandated to assign one BHW per 20 households that they cover, in Bataraza only one *barangay* has attained this. In reality, BHWs can be assigned anywhere between 20 to 300 households. Each week, BHWs are required to spend 2 days working in the *Barangay* Health Station and the RHU or *barangay* midwife assign BHWs like Elyn work which could be in the station itself or out in the community like distributing Filariasis medicine or vitamin A tablets. In addition, BHWs are then expected to visit their households in order to check on patients and administer advice and treatment. Accordingly, as well as conducting her duties at the station, Elyn visits her 200+ households throughout the week. She is given a thermometer and a stock of Paracetamol from the RHU but as she is also an RDT technician, Elyn carries an extra bag containing bottles of alcohol, cotton swabs, packs of RDTs and first-line malaria treatments like Coartem (to treat *Plasmodium falciparum*) and Chloroquine (to treat *Plasmodium vivax*). In addition, Elyn also knows about a number of other herbal treatments for a range of illnesses including malaria and she carries some plants with her from her own garden or things she picks from the gardens of neighbours or patients on her rounds. This knowledge has been passed down to her from her ancestors as described above. As such, Elyn sometimes recommends the use of herbal medicines to her patients for a variety of ailments, as beyond anti-malarials and Paracetamol, she has no other treatments that she can offer. For malaria in particular, Elyn sometimes prescribes the use of herbal plants like *sambong* to lower the fever in addition to other allopathic medicines that she has.

As well as testing and treating people on her rounds, Elyn tells me that, every week, she also has number of patients come directly to her house presenting with a wide variety of symptoms but all reporting that they have malaria. Regardless of what her patients 'believe' that they have, Elyn always performs an RDT if patients are suffering from the symptoms she knows from her training are consistent with malaria; fever, chilling, fatigue, headaches and body pain. As she explains:

‘most of the people come to me and say that they have malaria but they don’t know if they have really. In order to know you must test the blood.



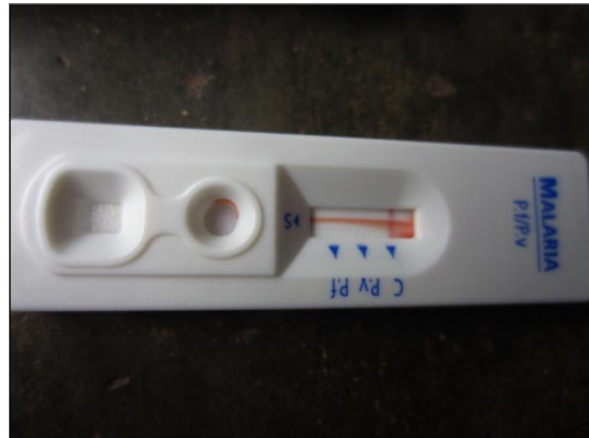
In the microscope you can see the parasites but in the RDT [Rapid Diagnostic Test], it shows up a line if there are parasites. Many people that come to see me know I am an expert in doing RDTs so they come here when they suspect they have malaria but in actual fact most of them do not because the numbers are very low here. They maybe have other things like Dengue or UTI [Urinary Tract Infection]. In that case, I will tell them they must go to the RHU [Rural Health Unit] to have the proper treatment'

I was able to experience first-hand how Elyn performs such diagnostic tests as during my time in the field, I became ill with a high temperature and headache. When I told Elyn, she insisted that she perform an RDT on me to check whether or not I had malaria. The next day, she brought her testing kit with her to one of our interviews and set about testing me. She wiped my finger using a cotton swab soaked in alcohol; pricked my finger with a needle and used a plastic blood-transfer device to place a drop of the blood in the sample window on the test cassette (See Figure 5.4). Buffer solution was added in the appropriate hole and then we waited for 15-20 minutes to see the result. Thankfully, a red line appeared in the test window confirming that the result was negative (See Figure 5.5). As is consistent with her training, Elyn advised me to still have a blood smear test at the RHU as she explained that the parasite count in my blood could be too low to be detected by the RDT.

**Figure 5.4 Photograph showing Elyn performing an RDT test on me. Source: author.**



**Figure 5.5 Photograph showing my negative result for malaria on an RDT test.**  
**Source: author.**



### **5.5 The pharmacist**

Illaine is a woman in her 40s who, although ethnically Ilocano, was born in the Municipality that neighbours Bataraza, Brookes Point. Illaine is widowed and lives with her three children in the town of Bataraza. She employs three young girls to work in her house and business who also live with her. Illaine studied Pharmacy in Manila and, after finishing her degree, moved back to Palawan. She married her husband in the early 90s and then decided to move to Bataraza in order to open a small pharmacy. At the time, there was neither a major town centre in Bataraza nor any roads linking it with neighbouring towns. Only a few migrants lived in the centre and the remaining forested areas was largely inhabited by indigenous people. There was no major infrastructure including roads or electricity. At the time, her small pharmacy was the only one in the area and she is still the only licensed pharmacist in the area. This is something Illaine is keen to remind her clients of and her certificates are framed and hung on the wall of the pharmacy next to a collection of medical textbooks and reference guides which she regularly dips into during consultations with patients. Although her business has grown considerably, and is the main private provider of drugs, maintaining herself as a 'legitimate' practitioner is key to Illaine's success as there are now a number of other much smaller licensed and unlicensed pharmacies in the town as well as many *sari-sari* stores [road-side shops] that sell a range of drugs. At the weekly market in the town centre, it is also possible to buy drugs but many are counterfeits that are said to come

mainly from Malaysia and China. Inspectors are based in Manila and only come to Bataraza once a year. Illaine told me that once the inspectors get to the capital of Palawan, Puerto Princessa, shop owners text each other to give each other prior warning that the inspectors are coming. The unlicensed shops will temporarily close down and their owners will leave town to avoid the inspectors. Illaine laughs as she tells me how, unlike them, she actively welcomes the inspectors into her store as she has 'nothing to hide'.

Having lived with Illaine for a year, I was able to learn a lot about her business as well as observe the way in which she and her staff deal with customers. The majority of her customers come to her shop asking for allopathic medicines without a prescription. In cases where customers ask for non-prescription drugs for 'mild conditions' including pain, coughing or flu, Illaine and her staff sell these with little discussion or consultation with patients. However, many customers do also ask for prescription only drugs such as antibiotics or anti-malarials. Prescriptions are given by the doctor but, as described above, the doctor is hardly present in the RHU. Although the Medical Technician is also authorised to issue prescriptions, many people do not visit the health clinic at all before going to the pharmacy. In these cases, Illaine will enter into discussion with patients, often referring to her books, to make a diagnosis and recommend the best course of treatment. However, even when she knows and suggests to patients that they need to have further tests done to clarify the underlying cause of their illness, Illaine, and her staff, will still often sell patients the drugs they want without a prescription. For example, although Illaine knows what the current first-line treatments are for malaria and that it is not advisable to give anti-malarials to people who have not had their malaria confirmed by a diagnostic procedure at the health clinic, she still tends to sell these drugs to customers who ask for them. As she explains:

'If people come here with a fever I tell them they should go see [the Medical Technician] first to get a test and see if they have parasites inside and then he will give them drugs for free if they are positive [for malaria] but even when people don't want to do that, I will still sell them anti-malarials if they ask for them. People are poor and cannot afford more than a few tablets. I tell them it is not effective to take only few [tablets] but what can they do? I feel sorry for them so I still sell them. Most people say they have malaria when they have any illness, always

malaria malaria. They want Choloroquine even though it is only effective for *vivax*. I will still sell them Choloroquine as it is very cheap compared to other drugs – sometimes even just one or two tablets but I don't think they always have malaria – it's just to give them something, otherwise maybe they won't come back here to my store! [laughs]'

As well as allopathic drugs, the pharmacy also sells toiletries, confectionary and a wide range of 'herbal' medicines including licensed herbal tablets and teas. Various kinds of incense and gem stones that have their roots in Chinese medicine have also become very popular with customers in recent years who buy these products to use alongside other medicines. For example, one patient came to the pharmacy complaining that her young daughter was repeatedly sick with different afflictions. The mother told Illaine about a range of illnesses that the daughter had suffered from over the past few months including repeated headaches, flu, fever etc. Although the young girl tended to get better after treatment, the mother was concerned about the underlying reasons for these frequent episodes. The woman, who was Catholic herself, asked Illaine if she thought it could be that the child was being tormented by spirits. Illaine told the woman that it was possible but she was not able to make such a diagnosis and advised her to talk to her priest who would be better placed to tell the woman if spirits were behind the child's afflictions. However, Illaine did recommend that she buy a small red cloth envelope which, if pinned to the child's clothes, would act as a repellent to malevolent spirits. She also sold her some black coal which she advised to be burnt and carried around the whole house seven times in order to dispel any spirits which might be present in the house and afflicting the child.

## **5.6 The practice of professionals**

Sario, Nicanor, Elyn and Illaine all distinguish themselves (and are distinguished by others) as certain 'types' of healer: a *balyan*, *manghihilot*, *Barangay* Health Worker and Pharmacist and these can be further categorised still into labels like 'formal' or 'informal', 'traditional' or 'biomedical'. However, the knowledge and practices of all four healers do not necessarily map neatly onto the discrete boundaries implied by these labels and instead are, in reality, somewhat 'latticed' (Parkin, 1995 cited in Hampshire and Owusu 2013) in nature. Depending on the situation, 'biomedical' healers like Elyn and Illaine employ not just 'biomedical', but also 'traditional' and even 'religious'

knowledge and practices. Similarly, ‘traditional’ healers like Sario have knowledge of ‘modern’ diseases like malaria which are incorporated into their understanding of health. Others, like Nicanor, are even keen to work with and exchange knowledge and practices with ‘biomedical’ doctors in order to both help patients and garner their own prestige as experts in ‘traditional’ healers. Rather than healers fulfilling certain ‘roles’ within certain systems, their practices are in fact similarly orientated because of the shared strategic intention that healers have – that of establishing themselves as ‘professionals’ (Last and Chavunduka 1986) *in relation* to their patients. Legitimization is necessary in order for these practitioners to attract and treat patients within the therapeutic landscape of Bataraza. This professionalization is conferred by a number of important factors like specific training, expertise and instruments that I go on to discuss in more detail below. As a result, the malarias that are done by professionals, although heterogeneous in that they too, do not necessarily neatly *reflect* specific systems or traditions of knowledge, are still united in certain ways precisely because they are *enacted* in accordance with these practices of professionalization. As a result, they ‘hang’ (Mol 2002) together because they are all objectified and ‘hidden’ inside bodies requiring trained professionals to use their expertise to uncover or ‘see’ them before they can be dealt with using specialised instruments.

### ***5.6.1 Training to be a professional – the ‘calling’***

Despite their differences, all of the healers mentioned above are considered professionals predominately because of the training that they have undertaken. This has been acquired by a combination of ‘formal’ (i.e. government approved) and ‘informal’ training, as well as through ‘hands-on’ experience. Crucially, this training means that all are also recognised by their patients, the wider community and even each other, as being professionals.

In the case of *balyan*, the ability to heal has an inherited quality as the knowledge and skills related to herbal treatments are largely handed down through generations from the ‘ancestors’. Sario inherited not just knowledge, but also objects like his *tari-tari* from his father. However, this hereditary quality is not a prerequisite for the position as anyone can technically become a *balyan* if sufficiently trained and more importantly if they have had a ‘calling’ to do so. All *balyan* that I spoke to had had such a calling which shared some common characteristics. First, they had a mystical experience of the

*kurduwa* (soul) that occurs mostly during dreams but can even occur through experiencing (and then being reincarnated from) death. Secondly, the experience usually involves meeting a character, often a child or older person who asks them where they are going or what they want and then at some point offers their help or assistance by providing knowledge about treatments. In many cases, *balyan* become linked to their *diwata* helpers throughout their lives through the establishment of a sibling relationship. Apart from a calling, acquiring knowledge about treatments is a lifelong endeavour and many *balyan* also undergo a kind of apprenticeship from relatives or close friends in addition to *diwata*. There is a sense that although anyone can become a healer, a master would only agree to share his knowledge with those that have the ‘right’ kind of personality and who display loyalty by mirroring his practices. As one apprentice explained:

‘The student has to be interested and show he is keen and committed to learn. The teacher has to see first his sincerity and loyalty to him as a teacher as if he is your father and you his son and then if he sees these good qualities he will teach him’

*Male apprentice*

Outside of the Palawan context too, training is an essential part of the establishment of oneself as a professional. In the case of Nicanor, like most other *manghihilots* that I encountered, although not an inherited title as such, particular circumstances around his birth have predisposed him to become a *manghihilot*. Nicanor was born with a snake sibling who was able to train him and others that I spoke to were born *suhi* (Tagalog for breeched) endowing them with, as one female *manghihilot* explained, the special ability to feel people’s ‘bones and veins’. While Nicanor was not officially registered at the Municipal Hall as a government-approved healer, many like him are. In the Philippines, *hilot*<sup>5</sup> training began 1954, and as such, registered practitioners are able to attend training courses to qualify as ‘formal’ professionals. Nevertheless, Nicanor is acknowledged in the community as a renowned healer and this is, in large part, due to the ‘informal’ training that he received from his snake sister.

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<sup>5</sup> *Hilots* (Tagalog for massage) are roughly divided into two categories: *manghihilots* (chiropractic practitioners); and *magpapaanaks* (birth attendants).

Similarly, both Elyn and Illaine have gained a reputation as professionals due to their training through which they have attained qualifications and certificates that prove their 'special' status. Both women were extremely proud of the knowledge that they gained through the formal seminars and courses that they had attended. Illaine in particular, keenly displays her certificates on the wall of her pharmacy in view of all her customers. They act as a badge of her professionalism to her patients that set her apart from her less qualified competitors. However, as in the case of Elyn, healers can have training from multiple sources. While she is a 'formally' (i.e. government-approved) trained BHW and RDT specialist, she has also received training of another kind, from her ancestors, and she regularly employs the knowledge and skills gained from this in her role as a BHW/RDT technician.

The training that each of these healers has undergone, endows them with certain esoteric knowledge and skills that their patients lack. All healers take steps to keep this distance between themselves and their patients (and between each other to some extent) by keeping their knowledge and skills somewhat secret. As described in chapter 2, *adat pagbagi* (sharing) and *tabang* (mutual help) are crucial to the maintenance of social relations and very strong forces in Palawan culture. In my work, I found that this concept of sharing did not pervade the realm of healing in the same way. While all *balyan* were keen to help sick people, and felt it was their calling to do so, this excluded the idea of sharing their specific knowledge or practices with patients, friends, neighbours or even family. Most *balyan* that I spoke to were extremely cautious about talking about their relations with the spirit world, and in particular, their possession of *anting-anting* (Palawano for charms). In general, the reason given for this secrecy was the fear that the 'power' would lessen the more it was known about or talked about. This would reduce the efficacy of treatments and interventions. In addition, pride and arrogance are seen as negative personality traits for the Palawan and highly offensive (Macdonald 2007) whilst modesty, meekness and mildness, are 'valued to a high degree' (ibid: 139). As one *balyan* explains:

'To make it a secret is the most important thing because the more it is secret, the more effective it is. If you boast about it then the power will diminish. It comes back to the spirituality and the mentality of *Ampu* [Palawano for 'God'] - to have patience and the attitude of 'come what

may'. For example, if somebody is sick over there, I cannot say 'oooh I know how to heal you – I know the healing practices, the herbal medicines for your sickness'. That is bad. That is bad . . . because you are boasting, being proud and lifting up yourself and anything you apply will have less power – it will not be effective. Come what may. That means that when a person comes then I'm not saying anything and later on, that person might say 'I want you to heal me'. If he insists that they want you to heal them then that is ok. You cannot announce it yourself in front of people but if they come to your house then it's ok because that means they are willing'

*Male balyan*

This secrecy extends outside of the Palawan context too. For example, Nicanor keeps the exact contents of his oil a secret from his own children. While it does not necessarily manifest in the same way, healers like Illaine also display a certain amount of secrecy in terms of their practice. Illaine has invested many years learning her craft and regularly updates and refreshes this knowledge by referring to her books that she keeps on a desk in the pharmacy. Significantly, Illaine's books are all in English and require a certain level of educational, and specifically scientific attainment. This makes this knowledge accessible to her in a way that it is not to her other staff and certainly not to most of her customers. Although she hires a number of staff at the pharmacy and imparts some knowledge to them regarding pharmacology, she is discriminating in terms of which staff she deems worthy to receive this knowledge. She describes this as an issue of practicality – she does not have time to train all of them in depth. However, her staff interpret her actions differently. One of them confided in me regularly about how Illaine treated her differently to the others because they had a special relationship that was more akin to mother and daughter than employer and employee. She told me 'she does not trust the others because of so many problems she had [with them] in the past . . . so she only teaches me. Maybe it is her plan that I can take over this pharmacy one day'. It was certainly true that I saw Illaine invest a lot more time in teaching this particular staff member as well as encouraging her to talk to me in English to help her better understand her medical textbooks.



The malarias that are enacted by various healers vary in terms of their cause and treatment. However, they are all done so in accordance with practices of professionalization that are enacted *in relation* to patients. As a result, these malarias are united because they all require the use of specialists to deal with them. Even those healers who lack the ability to diagnose malaria like Illaine, or to treat it like Sario, still refer patients that they suspect have malaria to *other* specialists. As described in the next chapter, this is in contrast to the malarias that are *done* by patients, who, in their quest to get better, do not always consult with or require the use of professionals at all.

### ***5.6.2 The expertise of the healer – a conduit to the unseen***

As these examples reveal, all of the professionals above serve a similar and important function that sets them apart from their patients; they are able to determine or ‘see’ the ‘underlying’ causes of illness. In the Palawan context, healers are instrumental in bridging the worlds of the seen (human) and the unseen (*Ampu* (God), spirits, souls, ghosts and magic) that, as described in chapter 2 are common causes of illness. ‘Regular’ humans are not able to ‘see’ the causes of their illness nor the spiritual agents that can possibly cure them. This is in contrast to healers who derive their power directly from their ability to do so. As well as seeing, the healer can also communicate with these unseen forces. To do so, unseen agents also need to be able to see healers themselves. An example of this is the brightly coloured clothes that *albularyos* like Sario wear during healing ceremonies which allow the spirits to see him.

Outside of the Palawan context too, healers like Nicanor, Elyn and Illaine are also considered to be experts who can determine unseen causes of illness. All made reference to external agents that are able to permeate bodies and bring about malaria. Elyn and Illaine reported how they stressed the need for patients to have blood smear tests or RDTs in order to ‘show’ whether or not they had parasites in their bodies/blood. Due to their biomedical training, both women referred to things like parasites, viruses and germs which are generally not articulated by most Palawan informants that I spoke to. In this context, healers like them refer to unseen causes of illness that need to be looked at, identified and counted with the use of specialist equipment like thermometers, microscopes or rapid diagnostic tests in order to be expelled from the body. This is perhaps somewhat in line with Foucault’s (1973) notion of the ‘clinical gaze’ whereby the body is objectified as a site for observation,

measurement and treatment. In order to uncover these hidden malarias, healers must employ tools like RDTs and microscopes or, in the case of Nicanor, perform incantations, observations and massage. As a result, the malarias that are done by healers entirely *depend* (Mol 2002) on the objects and the practices which are needed to see them.

However, it is important to note that although the ability to 'see' what patients cannot, demarcates healers as professionals, the act of seeing malaria does not necessarily govern the practices of healers. For example, although Illaine knows that before having treatment, customers should have their blood tested so that parasites can be identified, she nevertheless still sells them the anti-malarials that they ask for anyway. She articulates that the reason is a combination of feeling 'sorry for them' and the fact she wants them to 'come back' to her store. Her practices are therefore motivated by her business needs to maintain her status as a professional who, despite not being able to uncover or see the cause of illness, can still offer her patients something they need but lack; either knowledge about where to go to have illnesses seen, or, more importantly, healing objects (drugs) that can make them feel better. This is significant as it suggests again, that the practices of healers are motivated less by the presence (or knowledge) of malaria itself (nor by the lack of it) and more by the maintenance of the social relationships that surround these practices.

Through the practice of their expertise, healers enact malarias that exist as separate entities, hidden 'inside', what is framed as objectified bodies that are afflicted *with* malaria. Sario describes 'things *in* the body' that he cannot see; Nicanor looks (and feels) for evidence of the 'dirt' that causes his patients' *baso-baso* (Palwano for abdomen) to swell with malaria and their lips to whiten; Elyn looks at the RDT cassette for proof of 'parasites' in my body; and Illaine, often advises her patients to go to the RHU to have a blood smear test in order that they 'see if they have parasites *inside* their blood'. As such, the malarias enacted by healers are ones that exist as separate entities (as 'things', 'dirt' or 'parasites') to bodies (although located within or inside) that ideally need to be 'uncovered' or 'seen' by professionals before they can be treated. These contrast with the malarias of patient discussed in the next chapter, that are felt very much inside their own bodies, and rather than be uncovered or seen, need to be balanced in order for them to 'feel better'.

### 5.6.3 *Anting-anting (charms) and healing objects*

All the healers mentioned above are also united in their possession of certain powerful objects that they use to heal their patients. All Palawan healers that I spoke to were in possession of charm-like objects that were a source of power. While these usually took the form of stones or seeds (See Figure 5.6), this also extended to words and incantations. Sario described the stone he was given by a spirit that appeared to him during his calling that allowed him to hear the spirits when he put it to his ear. Other *balyan* acquired their *anting-anting* from their ancestors. However, as with the passing on of medicinal knowledge, the decision to give someone such a possession is not a decision taken lightly. Only those who prove themselves 'worthy' are likely to inherit such objects and some people never endow theirs to anyone in life. *Anting-anting* are potent objects, imbued with an essential *ginawa* (Palawano for life-force) from which give the *balyan* power that he must be able to manipulate. The possession of *anting-anting* is a covert affair and people are generally reluctant to discuss the issue at all let alone reveal that they own some. It was only once I had established close relationships with various healers that they told me about their own *anting-anting* and any discussion about them was always punctuated by mumbled prayers to *diwata* as well as the heeding of omens, such as lizards croaking that indicated warnings to end the conversation from the spirits. Some healers I spoke to were not willing to discuss the topic at all becoming visibly uncomfortable and guarded. The reason for this secrecy is that just talking about *anting-anting* could reduce their power and potency.

**Figure 5.6 Photograph showing examples of *anting-anting*. Source: author.**



The potency inherent in objects like *anting-anting* is also found in the objects that healers use to heal such as the *rocoroco* and *silad* used by Sario. It is also present in all herbal medicines and repellents like the *pananga*. *Rocoroco* is so powerful that, even after it has been used in treatments, it is often preserved by being tucked into walls or rafters and is not to be touched. In this way, healers conceive of their power as ultimately coming from *Ampu*, the maker of all things, and passing through them and the objects that they use to heal.

Other healers too possess a number of potent objects that they can use to heal patients. Nicanor's oil is so important that without it, he claims he would be powerless. In addition, healers like Elyn and Illaine use a number of allopathic medicines. For example, Elyn carries Paracetamol and anti-malarials (Coartem and Choloroquine) with her and regularly administers them to patients; the former for ailments including pain and fever and the latter only for those patients she has confirmed have malaria. As a pharmacist, Illaine's whole practice centres around medicines, about which she has spent years of her life gaining expert knowledge including how the active ingredients in drugs work and react with each other. For Illaine, one of her major concerns is ensuring that the drugs she supplies are legal and of the best quality, as opposed to the numerous counterfeits available to people. In this sense, her healing objects are both symbols of and constructs of her authoritative professionalism (van der Geest and Whyte 1989).

As a result, illnesses of professionals cannot be treated by patients themselves. Rather, once identified by a specialist, they also require the use of expert and potent objects to treat them. Again, as described in the next chapter, the illnesses of patients do not always require the use of such expertise particularly if less expensive or more easily available means are at their disposal that simply help them 'feel better'.

## 5.7 Conclusion

In this chapter, I have demonstrated how the practices of healers that surround malaria do not simply *reflect*, but *enact* what it *is* within the field of professionalization. This is illustrated here by the examination of four healers whose practices (and the malarias enacted alongside) align with their establishment of themselves as 'professionals' (Last and Chavunduka 1986) *in relation* to their patients. As such, these malarias 'hang' (Mol 2002) together as objectified things, 'hidden' inside bodies that require trained

professionals with expertise and instruments to uncover and treat them. As discussed in the next chapter, these malarias exist in relation to those of patients whose practices are orientated towards a very different strategic aim.

## Chapter 6: The malarias of patients

In this chapter, I explore what patients do when they fall ill. Looking at these practices, reveals that for patients, illness are subjective experiences felt within their bodies that make them *feel sakit* (Tagalog for sick). The practices of patients are thus orientated towards their shared strategic aim of 'feeling better' and maintaining feelings of wellness. To do this, 'imbalance' in the body or the wider community needs to be restored and then maintained. As a result, patients' practices are situated within a wider set of domains than that of just the patient/healer dyadic as they incorporate much broader concepts of health, well-being and social order. The pragmatic approach that patients take to achieving bodily and social balance and well-being means that their practices: are neither always predictable nor linear and often involve 'straddling' (McMillen 2004; Hampshire and Owusu 2013) multiple systems; can be characterised by features like ambivalence and fatalism which counter intuitively perhaps, might facilitate, rather than inhibit action; and are often a communal issue between families and community members that do not always require the consultation of professionals. These points are illustrated by the examples presented in this chapter of what four patients from the Palawan community (Naricta, Isabelle, Nelsa and Bernas's father) did when they were sick with what they suspected was malaria, or illnesses that they described as being very similar to malaria and how they then maintained these feelings of wellness and balance in order to prevent illness. As in the previous chapter, these examples have been chosen as they are illustrative of common themes that I came across. Above all, they demonstrate what I contend to be the primary concern of all the patients that I encountered - their desire to 'feel better' and maintain wellness.

### 6.1 Narcita's malaria

The excerpt below is taken from my fieldnotes and is the first example that I came across of someone dealing with malaria:

'A woman who had been preparing food in the house next door, came out holding some leaves in her hand which she said were a treatment for malaria. She said she was preparing them now to take because she had been sick for three days. She had picked them from the garden of her neighbour 'down there'. I asked her what she had done over the last

three days to treat her malaria and she said nothing until now. I then asked her if this was the first medicine she had taken and she said no, she had taken one tablet of paracetamol on the first day that she had fever. After she took the paracetamol she felt a little better so she rested and did not take a bath before sleeping. The next day she was still sick and wanted to rest more but had to go to work because she had already made the arrangement to do *arawan* [wage labour]. She says she got sick because she was out working in the sun and got very hot but then it rained. I asked if you can get malaria any other ways and she said from mosquitoes but said that the reason she got sick this particular time was because of the changes in climate which made her feel weak. She goes on to tell us that she knew that her neighbour grew this medicine (she can't remember the name) so she went to pick some on the way home to making her lunch and then she will return to work again. She will keep drinking the juice from the leaves until she is better and will make sure to eat a lot of rice. I ask her if she can go to see the *Barangay* Health Worker or go to the *Barangay* Health Station to have a blood smear test as they are close by and she could get there and back in the time for lunch. She tells me that although they can give her stronger medicine, she can't go there because her husband is out doing *arawan* and her children are at school so she has no-one to go with her. In any case, now that she has the leaves, it is not so urgent to go the health clinic because she knows these will make her feel better. She says they are like a 'first-aid' treatment for when you cannot get other kinds of stronger medicine'

## **6.2 Isabelle's recurring body pain and fever**

When I was conducting questionnaires with adult caregivers, a mother called Isabelle apologised for not attending her scheduled time slot the previous week and explained that she had been sick with chronic body pain and fever. Thinking that this might be relevant to my study, I took the opportunity to interview her regarding her illness:

'I was up there [pointing towards the mountain] doing *kaingin* [swidden farming] and harvesting the bananas and suddenly I felt something hit me from the back and then there was *sakit* [pain] all the way in my body. Some months later, my daughter came home from Puerto and she asked

me if she could have some bananas to take. I told her to go up there and get them from our *kaingin* field but she said 'no' so my husband told me to go there and collect bananas for her. When I was there I also collected some corn and was carrying it back in a large basket on my back. When I was walking on the road I felt someone was pulling my basket and I felt a sharp pain again in my back as if someone had pushed me. I looked around to see who had pushed me and there was no one there so I was shouting for them to stop as I knew then it was *bati* [greetings from the spirits]. I ran home and from that time I have had pain in my neck and shoulders and back. Since then, maybe years ago, I get sick all the time with pain and fever. I went to the RHU for treatment but they told me 'this is not . . . malaria . . . so we cannot treat it'. So now I go to the *albularyo* [Tagalog for herbalist] and he gives me treatment but still I keep getting sick again and again with this body pain and fever. . . I can prove it is *bati* because I get it when I go up there to the *kaingin* and then I go to the *albularyo* and I feel better but then I go there [*kaingin* fields] again to get the bananas or corn and I feel something attack me and then I get sick again. Some people are prone to get *bati* more than others and I am prone . . . Sometimes it is because your ancestors hurt the spirits when they were alive and so now the spirits continue to attack you or sometimes you could have touched or hurt the spirits directly in this life without knowing and so you are prone to *bati*. It is bad to be prone to *bati*. You can make peace with the spirits by making *atang* [offerings] to them. At the moment, my family is discussing together whether or not I should make the *atang*. It is a big decision so we are discussing now with the family if I should do it [or not]'

Following the interview, my translator engaged in a long discussion with Isabelle. My translator later explained what they had been discussing and provided his own explanation for Isabelle's illness:

'This is a very sad situation and you know, her illness is because of her life situation. Lately, her 14 year old daughter was raped by a man who is close with the Mayor. She was living with him in the town and he repeatedly raped her. Although he admitted it, his wife (who is a radio announcer for the Mayor) is defending him in public and the Mayor has taken no action to punish him. I was involved in the case to have the girl



removed to Peurto for her own protection . . . Isabelle has been to Puerto twice to try to find her daughter but cannot get any information about her. This is what contributes to being prone to *bati*. Like how do you say, her ‘misfortune in life’ or her ‘emotional distress’”

### 6.3 Nelsa’s headaches

When I was conducting the photovoice sessions, a student from the Palawan community was absent. She lived next door to the school so, after the session, I went to her house to check on her. At the house, I found Nelsa lying down and resting while her older brother cooked rice on the stove. Their mother was at the neighbour’s house and their father was out doing *arawan* (wage labour). Nelsa had woken up that morning with a severe headache on one side of her head, and had vomited, so had stayed at home. This was a common illness that Nelsa suffered from every couple of months and had done so for the last few years. She described it as a ‘sickness in the brain’ that she had had since childhood. When she was younger, her mother took her to an *albularyo* [Tagalog for herbalist] who she recalled ‘rubbed some medicine on [her] head’ that was effective in making her feel better in the short-term. Apart from that time, she had not been to see the *albularyo* again, nor had she been to see a doctor or nurse in the town. Nelsa can tell that she will get one of her headaches because she feels *pitig pitig* (a tapping kind of pain) in the side of the head which marks the ‘beginning of the sickness’. The morning of the day I saw her, Nelsa’s mother went to the nearby *sari-sari* store to buy her one tablet of paracetamol and one of Mefenamic acid (anti-inflammatory drug) which she took with water before laying down to rest. She did not take anything for her vomiting. A few hours later, Nelsa felt better but her mother told her to remain at home to rest and eat a lot of rice so she could recover her strength. When Nelsa’s mother joined us later she told me that she had no idea what the cause of Nelsa’s sickness was but did not see the need to take her daughter to see either the *albularyo* or the doctor because it was not a serious illness. Although her sister knew a lot about how to treat illnesses with herbal medicine, she lived far away (in the same *barangay* but in an upland area). Nelsa’s mother usually had enough money saved to be able to buy one or two tablets for her daughter from the store and was also able to pick *tawa-tawa* (*Euphorbia hirta*) from her neighbour’s garden which was also effective for relieving Nelsa’s pain in the short-term.

#### 6.4 The house of Bernas' father

A common sight in Palawan villages is the remnants of old houses: a single rotting post or discarded roofing materials. A widespread practice amongst the Palawan is *bayanihan*, the movement of whole houses following an illness. I witnessed this practice when I was invited to join a feast with the whole community. The family, which owned the house, had gone to significant lengths to mark this occasion. A pig had been slaughtered and speakers, which were blaring out music when I arrived, had been hired from the town. I was surprised that the reason for this large gathering was that the community had come together to carry the family's house about 20 metres further along the track. The mother had been sick and an *albularyo* had advised that this was the best course of action. I asked one participant, *panglima* Bernas, about this practice, which he said had been part of Palawan culture from 'time immemorial'. He recounted a similar experience he had had when his father became sick many years before:

'If a person has a problem, his problem is not only his own problem but we consider it a problem of the whole community. . . If it's a sickness like sweating and fever then, for sure, the cause of the sickness is the location of the house especially if the sweat is a lot and they have a high temperature and chilling. This is particularly if the sweating and chilling is repeating like one time in the morning and then again in the afternoon then, absolutely, the cause is because of the location of the house. Inside the ground we cannot see what it is – maybe bad spirits. For example, my father, built a very nice house with a grass roof. It was a very big house. After three months he became very sick. He was sweating in the morning and then again in the afternoon. So he called his younger brother and said 'please come and do the *tari-tari* [diagnostic procedure] in my house because I am feeling sick in the morning and the afternoon'. So he came and told my father to leave the house for a few minutes. He then started talking to someone in the house but it wasn't a person, maybe some spirits. When my father was going up the stairs of his neighbour's house he suddenly felt that the pain had gone. When he left his house he was better so his brother said that we had to wait until the afternoon and see what would happen next . . . By that time, my father got well and so it confirmed that it was the house. So he stayed in the neighbour's house one more night and then next day decided to

move his own house. . . So we got all the families together – maybe about 30 families. Once he moved the house he did not get any more sicknesses like that related to the location of the house. That's why *bayanihan* is a culture from our ancestors; it's not from Muslims or anything - just from *our* culture'

## **6.5 The practice of 'feeling better' and maintaining wellness**

The examples above help to illustrate that when faced with sickness, people's practices are primarily motivated by their strategic concern to 'feel better' and then maintain these feelings of wellness. Like healers, patients are less concerned with making sense of or even re-creating ontological boundaries in either their sicknesses nor the various healing options open to them. The illnesses including malaria that patients experience make them feel *sakit* (Tagalog for sick). In order to bring an end to these feelings, patients engage in a number of practices that are aimed at restoring balance *within* their bodies as well as in their wider social lives as well as maintaining this balance in order to prevent sickness. This is discussed in much more detail in the next section as well as some of the features of this pragmatic course that patient take.

### **6.5.1 Restoring and maintaining balance**

The examples above illustrate how diseases are enacted alongside wider shared understandings of the body, health and well-being which in the case of the Palawan, are structured around the central tenet of balance. For example, Narcita reports that she got sick with malaria because she was out working in the hot, dry sun but then it cooled down and rained. She knows malaria is also caused by mosquitoes, but asserts that the reason her illness manifested at this particular time was because she was weakened by the changes in climate. As well as by taking medicines like Paracetamol and the herbal plants that she has collected from her neighbour, Narcita treats her malaria by making sure to abstain from a cooling bath, taking rest and eating a lot of rice in order to restore her strength and prevent getting sick again. Similarly, in Nelsa's case, although the cause of her headaches are unknown to her and her mother, she makes sure to rest and eat more rice in order for her to maintain her strength. What links these practices is their emphasis on resorting and/or maintaining balance within the body as a means to both prevent and treat illness. It is this concept that is central to understanding how it is that patients enact illnesses like malaria and requires further consideration.

Multiple studies that explore health in various parts of the Philippines (Rosaldo 1980; Nichter and Nichter 1996) or amongst migrant Filipino groups have identified the principle of *Timbang* (Tagalog for balance) as central to concepts of health, nature and social relationships (Anderson 1983; Edman and Kameoka 1997; Becker 2003). As Anderson (1983) articulates 'health is a result of balance, illness is usually the result of some imbalance' (ibid.: 815). Balance also underscores much of nature and social life which have a symbiotic relationship with health and illness across the Philippines.

The idea of balance within the body is often linked to the tradition of humoral pathology which is found in many countries across the world, both historically and today. The mechanisms through which such ideas may have been transmitted to the Philippines from external sources is contested (Anderson and Anderson 1968; Hart 1969; Orso 1971; Rosaldo 1971) but it is acknowledged that the conception of health found across the Philippines does share some features with many other traditions including Greek, Indian, Arabic or Chinese. I found that some of these features were also fundamental to the way in which the Palawan people conceive of and experience health. Of particular importance to Hippocratic humoral pathology is the idea that illness is caused by an imbalance of forces within the body. As Tan (2008) explains:

'In classical Greek theory, these would be the four humors: black bile, yellow bile, phlegm, and blood. Balance is determined by the distribution of various attributes of living matter: hot and cold, wet and dry. This distribution is, in turn, a function of the relative properties of four natural elements: earth, water, fire, and air . . . Personalities were attributed to these humors, as we see in the terms "bilious," "melancholic" (black bile), "choleric" (yellow bile), sanguine (blood), and phlegmatic'

(ibid.: 92-93)

While not all of these specific ideas are pervasive amongst the Palawan, some elements do generally align with humoral pathology are consistent, most notably the importance of balance. As Anderson (1983) notes, the basic logic of health and illness in the Filipino context involves both prevention (avoidance of inappropriate behaviour that causes imbalance) and curing (by restoring balance). Of particular importance in the maintenance of equilibrium within the body are the dichotomous attributes of hot and

cold and wet and dry which are conferred in all living things by the elements of earth, water, fire and air. Remedies for illness are conceived of in terms of appropriate food, liquid or herbal intake (Rosaldo 1971) which also possess the attributes named above.

The Palawan do not have a specific term for “health” or “healthy” but associated terms include *metaba* (Palawano for fat or chubby) and *masubug* and *kaya* (Palawano for strong). People therefore feel they are well when they are strong, able to work or play and have a healthy appetite. People speak of fatness as a positive indicator of well-being and thinness as an indicator of illness. Few Palawan are in fact fat and obesity is not a concept people refer to. Conversely, people know they are sick when they feel weak or are unable to get up, work, play or eat. It is at this point that people will seek treatment. Too much pain is also an indicator of ill-health the Tagalog word *sakit* literally translates into pain, and is used in several Austronesian languages as synonymous with ‘illness’ (Tan 2008).

In terms of malaria more specifically, the long history of control and elimination efforts in Bataraza mean that there has been a large amount of investment, both in terms of money and effort, into various programmes over the last few decades. Consequently, malaria (locally referred to as *malarya* in Tagalog), is something that everyone, adults and young people alike, know about regardless of their personal experience with it. The vast majority of respondents I spoke to were not able to give clear answers regarding *what* exactly malaria is beyond it being a *sakit* (Tagalog for sickness). However, the most common definition given is that malaria is disequilibrium inside the body; although it is rarely expressed in exactly those terms and no reference is made to body humors. Instead, people refer to an internal bodily state: it *is* too much heat, too much cold, too much dirt inside the body etc. Similarly, the majority of people cited one or a list of manifestations of that state (what biomedicine refers to as symptoms): it *is* dizziness, headache, fever, chilling, stomach ache, vomiting etc. Interestingly, imbalance is usually expressed as an excess rather than deficit of something.

In most cases, internal imbalance is caused because of the body’s interaction with external elements which correspond to earth, water, fire and wind. Central to this idea, is the congruence between the internal body and the external environment. Participants commonly cite *pasma* as a cause of malaria which loosely translates as ‘exposure illness’

(Frake 1961). This tends to refer to the application of cold to heat or *vice-versa* or applying more heat to existing heat. The sun is the primary cause of too much heat in the body and 'too much sunlight' is a commonly cited cause of malaria. The hot and cold dichotomy is the most significant in relation to health but participants also referred to the dichotomous elements of wetness and dryness which is absent from many parts of the world where hot/cold complexes exist (Orso 1971). These two elements also need to be kept in harmony and are particularly affected by sudden changes in weather, especially fluctuations between dry sun light and wet rain and *vice-versa*.

As well as natural external elements like the weather, practices that people engage in also change the balance of internal bodily states. Physical activity and exercise are heat generating activities and partaking in too much physical exercise or work can aggravate excessive or unnatural heat in the body which can lead to illness.

Food is another important factor which affects balance in the body. Warmth is generally associated with health making food necessary for maintaining warmth, strength and fatness. It is very common for people to cite hunger as a cause of their illness and it is generally associated with the body becoming too cold. While participants associated many foods including vegetables with being healthy, it is important to note that not all foods will necessarily satisfy hunger. Rice is at the centre of every Palawan (and Filipino) meal and is a huge part of Palawan social and spiritual life. In terms of health more specifically, people reported the significance of rice in terms of satisfying hunger. In fact, a meal is not really considered a meal unless it contains rice (and often rice alone is enough) precisely because no other food can fill you up in the same way. At times when rice is unobtainable (e.g. specific harvesting times or lack of money), then substitutes like cassava, taro and sweet potatoes are eaten. However, the majority of people still described themselves as being hungry after eating non-rice foods. In order to stave off hunger and avoid illnesses like malaria, eating rice is key. This explains why both Narcita and Nelsa emphasise 'eating rice' as a practice that they engage in in order to regain/maintain their health.

Food (particularly rice) is central to Palawan (and Filipino more generally) ways of life that as well as helping to maintain the balance of the individual body, it also has symbolic importance for maintaining the social body. In chapter 2, I described how

crucial *adat pagbagi* (sharing) and *tabang* (mutual help) are to the maintenance of Palawan social relations. This is clearly manifested in the way swidden products are redistributed amongst family and community groups in which rice is most prized. The symbolic importance of the distribution of food is also reflected in the strong association between hunger and social exclusion. In an early photovoice exercise, I asked children to take a picture that reflected their mood and one participant took an image that reflected his feelings of loneliness that day as many of his friends were absent from school. When I asked him how looking at the picture made him feel he replied 'hungry'. Other children agreed – to be hungry is to be alone and *vice-versa*.

Like food, liquid also affects the balance of elements inside the body. Many health professionals told me that Palawan people were 'misinformed' and thought malaria was caused by drinking 'contaminated' coconut water. In response, health professionals emphasise the sterile qualities of coconut water as an antidote to urinary tract infections. However, in interviews with participants, I found that an association between coconut water and malaria was made by some people but it was not a particularly common view suggesting this was more of a stereotype imposed by health professionals. Contrary to the way in which health professionals articulated the issue, coconut water is not perceived of as being 'dirty' or contaminated but instead, the risk of drinking it is linked to the broader idea of being over-heated after work or exercise and then drinking cool coconut water. The application of cold to heat brings about *pasma* which in turn activates malaria.

In addition to the properties of hot/cold and wet/dry, various foods have different properties like salty, sweet, bitter, sour etc which too, need to be balanced against each other. For example, as one mother explains:

'Inside our stomach we have a glass *baso-baso*. It is part of our small or large intestine. When we eat sour food like green mango or vinegar it will go to the *baso-baso* and stir up the *malaria* there and it will run to the whole body. If it is not treated then it can get to a higher degree like *falciparum* . . . When we were young our parents told us not to eat mango or sour food because it will affect the *baso-baso* and we noticed when we were sick our parents would give us Camoquin or Aralen then more recently Chloroquine when we were sick'

*Adult female*

As well as imbalance of elements, people also describe imbalance in the body that is caused by the introduction of an external agent, specifically into the blood, but they are less clear about what the agent itself is. As one child described it, 'something scatters inside you'. When people do specify what the agent was, it is most commonly described as 'dirt' but the principle of imbalance is the same; 'there is too much dirt inside you'. I found that amongst patients there was no reference to pathogens and none of the young people or adults that I spoke to within the Palawan community referred to the viruses, bacteria or parasites. In terms of how external agents like dirt enter the body, mosquitoes were the most commonly cited explanation given. Participants expressed that mosquitoes can introduce dirt into the body through a variety of methods. Firstly, mosquitoes are attracted to and live in dirty places and to lay their eggs in stagnant and dirty water. After being in such dirty places, mosquitoes have the potential to introduce dirt into the body directly by biting people. Secondly, directly drinking water, eating food or breathing in air contaminated with mosquito eggs or saliva was another possible source of getting malaria. Thirdly, some young people also mentioned that swimming in dirty water contaminated with mosquito larvae was another possible way to get malaria.

As well as through mosquitoes, external agents like dirt can also be introduced into the body through the direct consumption of 'dirty water' and 'dirty food' or through direct contact with dirty things like rubbish which contaminates hands or bodies.

While there are many sources of imbalance in the body, people are consistent in stating that imbalance in the body makes it more likely for malaria to 'come out' (as described in more detail below). The most commonly cited situations which put people, like Narcita, at risk of malaria 'coming out' are feeling weak, tired or hungry from excess work or exercise or under-eating. This corresponds to the more general association of health and being *metaba* (fat or chubby) and *masubug* and *kaya* (strong). As these respondents explain:

'When you are hungry, the malaria comes out. You already have the malaria from the mosquito bite but if you are hungry and weak then the malaria will come out'



*Adult male*

‘Also, when you have flu you are weak, then the malaria will arise and come out’

*Adult female*

‘When the mosquito bites you, you will have malaria in your blood but you will not feel it if you are strong but the moment you get weak then the malaria will work up inside you’

*Adult female*

‘One more thing – too much work, over fatigue. That’s the reason. You have a lot of sweat and the sweat dries in your body then you get malaria coming up’

*Adult male*

The idea that someone is able to have malaria without it negatively manifesting or ‘coming out’ is also consistent with many people’s view that all people are in fact born with malaria and it simply becomes a problem at particular times in their life when the body is in a state of disequilibrium or ill-health<sup>6</sup>. This came out clearly in a focus group with mothers:

‘Participant 1: When you are born as a Filipino, malaria it is there already inside.

Participant 2: Yes, I agree that when we are born we have that malaria inside . . . because even young babies experience fever and chilling’

*Adult females during a focus group*

Many respondents described how malaria remains in the body and can manifest in several attacks in a person’s lifetime. In this way, malaria can be brought on by increased disequilibrium or can incrementally increase inside the body if brought about by external agents like dirt. Many participants talk about ‘*falciparum*’ and describe this as an intense *amount* of malaria. Respondents were familiar with the gradations given

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<sup>6</sup> Similar to Geissler’s (1998) findings regarding understandings of worms and the body among the Luo of western Kenya.

alongside official diagnoses in health clinics whereby health staff informed patients of the stage of their infection. People therefore refer to having different degrees of *falciparum*: *falciparum* 1, 2, 3 or 4. In one focus group with mothers, women described that *falciparum* was the same as malaria but 'a higher degree of sickness'. This also aligns with the idea that malaria can be added to or '*tumaas*' (Tagalog for increased, topped-up) throughout one's life. As this respondent who suffered multiple attacks of malaria as a young boy explains:

'I don't know, but maybe, just maybe, you get bitten again by a mosquito so it adds to your malaria. Why else would it increase? Before you have just malaria, then you have *falciparum* 3, 3 years later. How is that possible? I think even if you are being treated with Chloroquine or Primaquine, it's not 100% that the malaria is taken away from your body. It's still *stuck* in there!'

*Adult male*

Participants therefore distinguished between the intensity of malaria but did not make any reference to different kinds. Very few participants outside of health staff, referred to different species like *Plasmodium vivax* or *Plasmodium malariae* which are also prevalent in the area or the idea that different types of malaria have different incubation periods consistent with a biomedical view of the disease. Some studies of malaria in other parts of the Philippines have found that participants distinguish between malaria of the liver (*malarya sa atay*), blood (*dugo*) or stomach (*pali*) (Miguel, Manderson et al. 1998). In the area of Morong, people similarly recognised twenty different types of malaria (Espino, Manderson et al. 1997). In my study, I found that people identified the strongest level of malaria, *falciparum* 4, with the brain but rather than being substantively different from other kinds of malaria, people expressed this as the malaria being so intense that it was able to *paglalakbay* (Tagalog for travel) or *tumakbo* (Tagalog for run) to people's brains, affecting their mental state:

'The most severe is *falciparum* 4. If you get that then you can become crazy. In Bataraza there a lot of crazy people from malaria'

*Adult female*

'I had *falciparum* 4 and by the time I reached the hospital I was unconscious'

*Adult male*

'*falciparum* is the same but it is a higher degree of sickness because it is so much, it attacks the brain and sometimes you are bed ridden'

*Adult female*

The distinction made in terms of the intensity of malaria also corresponds to symptoms. Both adults and young people have similar views about the wide range of symptoms that they associate with the condition. The wide spectrum of signs and symptoms that relates to malaria, combined with the intensive drive of control and elimination programmes has created a situation in which many people use the term malaria to refer to a whole host of conditions. Health professionals reported (and I observed) that most people presenting to formal health care facilities (including the pharmacy where I lived) with a very wide range of symptoms were sure that they were suffering from malaria regardless of having a confirmed diagnosis or not. Headache, fever, sweating, chilling, dizziness, fatigue and loss of appetite are generally associated with imbalance related to hot/cold. Stomach ache, diarrhoea and vomiting are considered to be as a result of too much dirt in the body or as a result of imbalance due to food elements. Malaria that is considered mild in intensity is characterized by symptoms that are regarded as 'manageable'. As described above, this relates to a more general association between health and strength and conversely illness and weakness. As symptoms intensify, and therefore people's ability to contribute to social order by getting up, working, playing or eating, so does the severity of the illness. Headache that is very severe signals malaria reaching the brain and chilling/shaking that is so intense it cannot be assuaged through the use of blankets or warming in the sun (Espino, Manderson et al. 1997) signals more intense malaria such as *falciparum* 1,2,3 or 4.

### ***6.5.2 Straddling different systems and the 'second spear'***

In the previous section, I described how the idea of achieving and maintaining balance is at the heart of understanding how patients fulfil their primary strategic aim of feeling better and maintaining wellness. Significantly, the pragmatic quest to achieve this equilibrium does not confine people to enacting practices within one medical 'system'.

In fact, patients, like the healers described in the previous chapter, also ‘straddle’ (McMillen 2004; Hampshire and Owusu 2013), transcend and contest (Marsland 2007) different therapeutic traditions, blurring the boundaries between various ‘systems’ of knowledge and practice. In the case studies presented at the beginning of this chapter, Narcita, Nelsa and Isabelle all consulted (or were open to consulting) healers from different backgrounds and both Narcita and Nelsa’s mother used their knowledge of both herbal and non-herbal medicines in treatment. They did not make any divisions between ‘biomedical’ and ‘folk’; ‘modern’ and ‘traditional’; ‘formal’ and ‘informal’ care. In fact, during interviews, informants did not really understand why I distinguished between ‘herbal’ and ‘non-herbal’ medicine as they just used the same word *gamot* (Tagalog for drugs) to describe all kind of medicine. Similarly, the word *mangagamot* (Tagalog for the one who heals) was used to describe all kinds of healers ranging from *balyans* and *manghihilots* to biomedical doctors.

This spanning of systems is significant because the vast majority of health-related literature centres around the idea of ‘first resort’ documenting what action participants initially take in response to symptoms or illness episodes. Implicit in this approach is the idea that there are objective ‘behaviours’ that can be separated out from the situated context in which they emerge and that these provide useful indicators of what people do in reality. Secondly, this approach implies that there is an inherent linearity (and therefore implied predictability) to human action that both exists in reality and can be captured methodologically. However, what people actually do in response to malaria is neither easily bounded and neatly categorised, separated from every-day practice nor is it, predictable or linear.

The case studies above help to challenge the assumptions that are implicit in the idea of ‘first-resort’. Firstly, the ‘first-resort’ approach tends to objectify certain ‘behaviours’ that are demarcated from much more every-day practices that patients engage in. These tend to be actions that are defined as being ‘appropriate’ within a biomedical framework. For example, a recent systematic review of the recognition of and care seeking behaviour for childhood illness in developing countries defined ‘appropriate’ care seeking as all care sought outside the home amongst ‘appropriate providers’ [that] included all government and trained private health practitioners, but not traditional healers, pharmacies and unqualified medical practitioners’ (Geldsetzer, Williams et al.

2014: 2). As a result, practices that relate to wider cultural understandings of illness are ignored such as Narcita's avoidance of taking a bath and eating more rice; Isabelle's avoidance of her *kaingin* fields and Nelsa's taking of rest and eating rice to regain her strength. This approach fails to take account of the fact that actions that patients take in relation to their health are often not easily distinguishable from other practices in their every-day life. This is best exemplified by the example of Narcita as the course she took was entirely contingent on the wider context of not only her own life but that of those around her like her neighbour, husband and children. She was unable to take rest, buy more paracetamol or use the services within her *barangay* because of her work and family commitments. Her good relationship with her neighbour meant she was able to go and pick medicines from her garden easily and for free and the absence of her husband and children meant she was not able to go to the health clinic to confirm her malaria and obtain alternative treatments. This example illustrates how health and social realities are woven together to such an extent that it becomes meaningless to identify specific health 'behaviours', divorced of the context in which they occurred. Disconnecting actions from the specific time and space in which they occur in tells us very little regarding the motivations and reasons behind why events unfolded as they did and alone. As such, they are only a poor indicator of real-life, situated practices. This example illustrates, in line with much counter research (Cohn 2014) that rather than behaviours, a consideration of 'practices' as they emerge *in* their context is more useful in incorporating the 'social, affective, material and interrelational features of human activity' (ibid.: 159).

Secondly, the examples above illustrate the lack of predictability and linearity in practices which are wholly tied to the situation in which they unfolded there and then. Linked to this is the realisation that 'health behaviours are not simply a function of knowledge or beliefs' (Jones and Williams 2004: 157). Many participants, like Narcita, have a high level of knowledge regarding aetiology, symptoms and care seeking alternatives for malaria that fit within a biomedical framework. However, this 'correct' biomedical knowledge sits alongside many other truths as people amass and adapt a whole repertoire of knowledge throughout their lives. From a patient perspective, biomedical knowledge is not compartmentalised into its own category but rather fits into and merges with broader concepts of health, well-being and social order that also

influence the way they act. For example, Narcita knew that malaria was caused by mosquitoes as well as the imbalance of hot/cold and wet/dry. She believed it was the latter that brought about her illness so this knowledge *did* influence some of her subsequent actions. However, Narcita also knew that she should go to the health clinic to have a test to confirm her malaria and that she could obtain ‘stronger’ drugs from there to treat her illness. In this instance, this knowledge *did not* influence her actions. Rather, than guided primarily by knowledge, Narcita’s decisions were informed more by the practical demands of her every-day life like going to work and preparing lunch.

This lack of linearity in practice is compounded by the idea that illnesses have multiple causes. For example, Isabelle’s sad situation with her daughter was described by those around her as being the ‘real’ causes of her illnesses. This echoes Evans-Pritchard’s (1937) description of witchcraft among the Azande where witchcraft acts as ‘second spear’ or *umbaga* explaining *why* certain events are harmful to humans and not necessarily *how* they happen. For example, when a man is killed by an elephant, the first spear is the elephant and the second spear is witchcraft, which caused the universe to place the victim in that particular situation prior to the attack. Both spears are necessary to kill a person (ibid.). Isabelle’s ‘misfortune’ in life was ultimately responsible for spirits attacking in her swidden farm. Both the first and second spears are necessary for the illness to take place and are not mutually exclusive. Accordingly, the use of multiple methods of diagnosis and treatment, although lacking predictability and linearity are, in fact, perfectly logical.

The case studies above also highlight the difficulty that researchers have in trying to document the ‘first’ action that people take when confronted with an illness. When I asked Narcita what she had done to treat her malaria, she replied ‘nothing’. This could indicate either an issue with recall and/or that what Narcita herself defines as ‘action’ differs from my own. These issues are also demonstrated by an analysis of the results of my questionnaire. I tried to capture participant’s action of first resort by asking participants to report both hypothetical and retrospective ‘first actions’ in response to malaria. Figure 6.1 and Figure 6.2 summarize the responses from young people and adults to these questions at baseline.

**Figure 6.1 Table summarizing the *hypothetical* first action that both adults and young people said they would take in response to malaria in baseline questionnaire.**

Reported hypothetical first action taken for malaria	Adults n=83	Young people n=113
Go to the Barangay Health Centre, n (%)	2 (2.4)	3 (2.7)
Go the Rural Health Centre, n (%)	24 (28.9)	48 (42.5)
Go to the Barangay Health Worker, n (%)	3 (3.6)	1 (0.9)
Go to the hospital, n (%)	1 (1.2)	1 (0.9)
Go to the traditional healer, n (%)	8 (9.6)	3 (2.7)
Take herbal medicine, n (%)	16 (19.3)	8 (7.1)
Cool the body with towels, n (%)	5 (6.0)	0 (0.0)
Take Paracetamol/Biogesic, n (%)	15 (18.1)	21 (18.6)
Take an anti-malarial, n (%)	2 (2.4)	2 (1.8)
Take Bioflu/Nusip, n (%)	0 (0.0)	1 (0.9)
Other, n (%)	7 (8.4)	3 (2.7)
Nothing, n (%)	0 (0.0)	4 (3.5)
Tell an adult first, n (%)	n/a	14 (12.4)

**Figure 6.2 Table summarizing the *actual* first action that both adults and young people reported taking in response to malaria in baseline questionnaire.**

Reported actual first action taken for malaria	Adults n=26	Young people n=40
Go to the Barangay Health Centre, n (%)	4 (15.4)	2 (5.0)
Go the Rural Health Centre, n (%)	9 (34.6)	14 (35.0)
Go to the Barangay Health Worker, n (%)	0 (0.0)	2 (5.0)
Go to the hospital, n (%)	0 (0.0)	0 (0.0)
Go to the traditional healer, n (%)	1 (3.8)	2 (5.0)
Take herbal medicine, n (%)	2 (7.7)	2 (5.0)
Cool the body with towels, n (%)	0 (0.0)	0 (0.0)
Take Paracetamol/Biogesic, n (%)	6 (23.1)	13 (32.5)
Take an anti-malarial, n (%)	2 (7.7)	0 (0.0)
Take Bioflu/Nusip, n (%)	1 (3.8)	0 (0.0)

Other, n (%)	1 (3.8)	0 (0.0)
Nothing, n (%)	1 (3.8)	0 (0.0)
Tell an adult first, n (%)	n/a	5 (12.5)

The results reveal that less than half of both adults (30/36.1%) and young people (53/47 %) reported that their first hypothetical action would be to go to an ‘appropriate’ health provider (*Barangay* Health Station, *Barangay* Health Worker, Rural Health Unit, Hospital) if they had malaria. However, proportions were slightly higher amongst the 26 adults (13/46.2%) and lower amongst the 40 young people (18/45%) who did so when they actually had malaria. These results suggest, in line with other literature (McCombie 1996), that hypothetical behaviour indicates only an approximate picture of actual practice.

As well as a disjuncture between the reporting of hypothetical and actual behaviour, these results also reveal methodological constraints when collecting direct data on actual behaviour through interviews and questionnaires. During qualitative data collection, I found that both adults and young people were quick to cite actions that they knew they ‘should’ do (i.e. usually related to seeking care outside the home with a formal health facility/provider) before they referred to other actions that they may have/would have engaged in before this action of ‘first resort’. In order to capture this in my questionnaires, I asked a follow-up question regarding what other actions people would or did engage in before their reported hypothetical or actual ‘first action’. The results that relate to participants who reported that their first action would or was to go to a formal health facility/provider are summarised in Figure 6.3 and Figure 6.4.

**Figure 6.3 Table summarizing the reported actions adults and young people said they would take before the *hypothetical* first action they would take for malaria in baseline questionnaire.**

Reported action before hypothetical first action taken for malaria	Adults n=30	Young people n=54
Go to the traditional healer, n (%)	14 (46.7)	11 (20.4)
Take herbal medicine, n (%)	14 (46.7)	24 (44.4)
Cool the body with towels, n (%)	20 (66.7)	31 (57.4)



Take Paracetamol/Biogesic, n (%)	22 (73.3)	37 (32.7)
Take an anti-malarial, n (%)	11 (36.7)	14 (25.9)
Take Bioflu/Nusip, n (%)	10 (33.3)	23 (42.6)
Tell an adult first, n (%)	n/a	51 (94.4)

**Figure 6.4 Table summarizing the reported actions adults and young people said they had taken before *actual* first action taken for malaria in baseline questionnaire.**

Reported action before actual first action taken for malaria	Adults n=13	Young people n=17
Go to the traditional healer, n (%)	4 (33.3)	4 (23.5)
Take herbal medicine, n (%)	6 (46.2)	9 (52.9)
Cool the body with towels, n (%)	7 (53.8)	9 (52.9)
Take Paracetamol/Biogesic, n (%)	11 (84.6)	13 (76.5)
Take an anti-malarial, n (%)	4 (30.8%)	4 (23.5)
Take Bioflu/Nusip, n (%)	3 (25.0)	8 (47.1)
Tell an adult first, n (%)	n/a	16 (94.1)

These results show that amongst adults and young people who said their first action would be or was to go to a formal health provider, many would actually engage or did engage in a number of other actions before doing so. Some of these, like cooling the body with towels or taking medicines (both herbal and allopathic) would constitute ‘home-care’ whilst seeking the care of a traditional healer, would be considered ‘inappropriate’ treatment.

In summary, these results suggest not only that practices are methodologically difficult to capture, but that in reality they are ‘messy’, unpredictable, non-linear and cannot be easily explained when separated from the specific temporal and spatial context in which they emerge.

### **6.5.3 Ambivalence, fatalism and the ‘bahala-na’ attitude**

It is not uncommon in the Philippines to hear people express frustration that Filipinos are, at best ambivalent and, at worst, fatalistic about their health. In many conversations

that I had about health, people told me that, to understand health in the Philippines, I had to understand the general concept of '*bahala-na*'. This commonly used phrase is somewhat problematic to translate and Gripaldo (2005) offers six meanings including: come/happen what may; do what you want, it's up to you, but be ready for the consequences; and let it be. For Gripaldo, this implies a particular world-view:

'The Filipino use of the phrase "*Bahala-na*" is fatalistic in the sense that it evokes resignation to the consequences of one's undertaking, but the intent of the phrase is providential in that it carries the wish or hope that Providence will personally take care of one's future . . . This worldview is Fatalism'

(ibid.: 208)

Consequently, *bahala-na* and fatalism have been cited as barriers to prompt health seeking behaviour amongst various Filipino groups in areas such as breast cancer (Wong-Kim 2007) and other life threatening situations (Vance 1995; McLaughlin and Braun 1998). In my work, some health-care professionals expressed the same problem. A doctor in the private hospital explained how the resignation he saw in patients can have fatal consequences:

'I have learnt to be very careful about telling patients if they were seriously ill as they immediately want to kill themselves. If someone is told they had fatal illness they would go home straight away and will not want to stay in the hospital even if we think there is something we can do to help them or to the relive pain'

However, consistent with Tan's (2013) recent review of the concept, the examples I have presented above illustrate how ambivalence, fatalism and the *bahala-na* attitude do not exclude action being taken to seek treatment, nor do they necessarily even delay it. Tan cites a reinterpretation of *bahala-na* by Lagmay (1993):

'Lagmay observed that the person who says "*bahala na*" does not avoid a problem; instead, he or she remains committed to meeting the problem, even while recognizing the difficulties or seriousness of it. Important for Lagmay was the improvisation or extemporization, as the person looks for ways to solve the problem'

(Tan 2013)

As already discussed, Nelsa and her mother, displayed a certain amount of ambivalence in seeking the *cause* of Nelsa's recurring illness. However, this did not translate into ambivalence about promptly *treating* it. Similarly, another participant that I spoke to about her friend's death, used the phrase directly saying, '*bahala-na*, we Filipinos know that we must enjoy life because one day you are here and the next not-there is nothing to stop it'. In the same conversation she expressed that this was also how she felt about her own husband's death from cancer, five years ago. This 'fatalistic' or 'ambivalent' attitude does not exclude participants from trying to help neither themselves nor others. Instead, as Tan (2013) suggests, when faced with the uncertainty inherent in illness, the concept of *bahala-na*, could perhaps 'embolden' (ibid.) rather than discourage action as people resign themselves to the idea that 'I'm going to do what I can' in this situation as one lives one moment to the next (ibid.).

#### **6.5.4 A communal issue**

As demonstrated by the foregoing, illness and health are issues for the group and community, rather than the individual. The cause of an illness can be due to the actions of others and, in the pursuit of healthy treatments, groups come together to pool knowledge, resources and decision making power. Here, all four patients relied on other people from within communities or families when they became sick. Crucially, these people were not always professionals. Within the Palawan community, I have already documented how sharing and reciprocity are important principles but that there are limitations. For example, specific kinds of food or knowledge are kept within families or small groups of 'trusted persons'. In this way, secrecy is an important way in which healers maintain the potency and therefore efficacy of their treatments. This is in contrast to the communality of treatment-seeking from the point of view of the patient. This is epitomised in the Palawan practice of *bayanihan* carried out by Bernas' father which involves the whole community group.

Within family groups, illness is also a communal issue. For Isabelle, her illness was a matter for the whole family specifically the decision about whether or not to make *atang* (offerings) to the spirits. This was considered a 'big decision' that was now being discussed and had to be decided upon together. To some extent, this reduced the amount of control Isabelle, as an individual, had on her treatment decisions. As a child,

Nelsa consulted her mother when she was sick and it was she who took her to an *albolaryo* and purchased or gathered medicines for her from their neighbour.

Even outside the Palawan community, the same principles apply. Sharing amongst family, neighbours and friends is extremely important but, again, there were certain limitations. A common phrase I heard was that, if a hungry neighbour came to ask you for vegetables or money at any time of the day, then it was imperative to help them. However, if they asked you for rice in the evening, then you should refuse. The idea being that, due to the importance of rice, asking for it at night implied the neighbour would not have time to return the favour by the end of the day and could potentially incur an unpaid debt.

The example of Bernas's father and that of Isabelle also help to illustrate the link between place, health and illness which contributes to the communal nature of sickness. As discussed in the chapter 2, in the Palawan context, the existence of invisible entities – be they spirits, ghost or dwarves – enlivens the landscape making it potentially dangerous to humans and governing the way in which whole communities live within it. Landscape is not a static and essential entity that can be objectified, contemplated and represented but is something that is created through interaction to the point where it becomes 'part of us, just as we are part of it' (Ingold 1993: 154). Following Hirsch and O'Hanlon (1995), landscapes are constructed through people's attempts to realise 'background landscapes' (site of potentiality for new interpretations) within 'foreground landscapes' (ibid.: 3-5). Although Isabelle and Bernas's father could not see the cause of their illness, as healers have the potential to do, they knew that, in certain everyday spaces, there were unseen forces that were causing them to become sick and avoidance of these places is something that they, as individuals, can do without the consultation of healers. As such, communities work together to designate and avoid certain places that they know to cause illness and participants often told me to stay away from places like 'that big tree over there where the spirits live' or 'that mound where the dwarf lives' in order to avoid getting sick. Isabelle is dealing with her illness by only going to her swidden field when it is strictly necessary and Bernas's father moved his whole house so as not to continue disturbing the spirits that lived there. This interaction between place and bodies illustrates how we are simultaneously 'embodied in place and emplaced in body' (Langton 2002: 260).

## 6.6 Conclusion

In this chapter, I have described the malarias that are *done* by patients and shown how their practices are congruent with their aim of 'feeling better' and then maintaining these feelings of wellness. This pragmatic approach means that patients' practices (and the malarias that they enact as a result) often span across multiple systems; can be characterised by features like ambivalence and fatalism; and are often a communal issue between families and community members that do not always require the consultation of professionals.

## Chapter 7: Summary of Part 1

In the last three chapters that have made up Part 1 of this thesis, I have tried to address my first aim of describing what malaria *is* in Bataraza. By focussing on ‘reality-in-practice’ (Mol 2002: 13), I draw on Mol (2002) in highlighting the multiplicity of disease. I have shown that there is not one singular and neutral malaria that exists as a solid, intangible, lone, ‘naturalised’ form. In fact, multiple malarias<sup>7</sup> exist inside (and in between) multiple bodies. Consequently, these malarias are *enacted* through the practice of various actors who are *situated* in time and space. Consequently, in order to understand any diseases, it is important to take account of the wider context in which it is enacted. Critical medical anthropology is a branch of anthropology that focuses on the macro-level factors that constrain individual action. Within this framework, close attention is paid to ‘vertical links’ – those that connect groups of people to the wider global, national and regional structures that organise the society in which people live (Mullings 1987 cited in Singer, 2004). In other words, this approach aims to embed culture within a historical, political and economic context. In relation to health care, this approach entails a focus on the influence of political forces (e.g. government policy) and economic systems (e.g. capitalism) that affect both the nature and distribution of health services and goods and the enactment and manifestation of various health realities. In terms of malaria more specifically, there have been a number of studies that have explored the dialectical relationship between political and economic structures and the way malaria is enacted (Cleaver 1977; Packard 1984; Elsey 2003; Espino, Beltran et al. 2004; Ghosh, Patil et al. 2012). Together, they highlight the need to examine malaria within its wider context and make reference to the historical, social, political and economic circumstances that ultimately help to co-create what malaria is in certain temporal and spatial contexts.

By taking such an approach, I am not so concerned with how people come to ‘know’ about a singular, fixed phenomenon or object of malaria. My focus is not on how actors cognitively ‘perceive’ *it* and consequently behaviourally *respond* to *it*. Instead, I have taken an alternative approach and treated objects like malaria as things that exist in the multiple which are subjectively *done* (ibid.) through practice that is *situated* in both

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<sup>7</sup> What Mol (2002) describes as ‘more than one, less than many’ (ibid.: 55).

time and space. Looking at how people *do* malaria highlights how actors interact with, shape and enact multiple (but inter-connected), situated, social malarias.

A focus on practices, or what Mol (2002) describes as praxiography<sup>8</sup>, runs the risk of fragmenting objects like malaria to the extent that every individual practitioner represents only their own version of it. However, as Mol (2002) points out, individual experience does not exist in a vacuum but rather coheres through a range of understandings and strategies that people share and enact in coordination. As well as people, malaria is also enacted by a collection of heterogeneous elements (ibid.: 26) like words, paperwork, mosquitoes, spirits, buildings, microscopes, medicines etc. To offer a way in to how these complex interactions play out, in Part 1 of this thesis, I have started with three groups of people in Bataraza: leaders, healers and patients. I do this in order to stress how individual experience is enacted *in relation* with others (including various non-human elements) in different domains or what Bourdieu (1977) calls 'fields'.

In her study of atherosclerosis, Mol (2002) clearly demonstrates *how* various actors coordinate their practices in such a way that makes multiple version of the same disease somehow 'hang together' (ibid.: 55). Here, I go further, by exploring *why* the practices of multiple actors co-ordinate and under what circumstances. To do so, I turn to Bourdieu's (1977) *Outline of a Theory of Practice* in which he offers a theoretical explanation of why practices co-ordinate. Bourdieu (1977) proposes that practice is 'regulated', not so much because people are 'obedient' to societal 'rules' or 'roles', but because they act according to shared 'strategies' and 'interests' within certain 'fields' (ibid.). These strategies are not necessarily conscious, deliberate intentions by the author but emerge in the moment in relation to 'systems of objective potentialities, immediately inscribed in the present, things to do or not to do, to say or not to say, in relation to a *forthcoming* reality (ibid.: 76). As such, Bourdieu (1997) elaborates the philosophical notion of *habitus* and suggests that human practice is a result of interplay between actors' inherited internalised dispositions (embodied structures) and their potential to innovate in line with their intentions. In the preceding chapters, I have shown how different malarias are not just functions of knowledge. This would imply that 'behaviours' develop in rational, deliberate response to knowledge. Instead, I make

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<sup>8</sup> As Mol (2002) explains in *The Body Multiple*: 'an ethnographer/praxiographer out to investigate disease never isolated these from the practices in which they are, what one may call, *enacted*. She stubbornly takes notice of the techniques that make things visible audible, tangible, knowable' (ibid.: 33).

the theoretical claim that malarias are functions of practice and are enacted through the *embodied habitus* that leaders, healers and patients engage in for potentially strategic reasons. As such, I have shown why they develop somewhat '*unconscious*' but nevertheless coherent strategies in relation to malaria under certain circumstances.

Despite the multiplicity of disease, the vast majority of people in Bataraza are united by two opinions: first that malaria, however it is defined and enacted, is a problem for individual human bodies or wider communities; and second that they want to take steps to alleviate it. I suggest that in order for individual or organisational efforts to succeed, the *situated, interrelational* and *unconsciously embodied* nature of enacted malaria needs to be taken into account. Accordingly, this may help malaria to be more appropriately dealt with precisely through methods that attend more to this level of *practice*.

Following this discussion of the nature of practice, in Part 2, I turn my focus to young people more specifically in order to address the remaining aims of this thesis – an exploration of how and why their identity is constructed as this has important implications for understanding their health-related practices as well as an exploration of how and why photovoice, as a method can be used as a way to reveal and potentially alter practice.



# Part 2

## Chapter 8: Growing up in the Palawan setting

In Part 1 of this thesis, I established the importance of exploring how multiple malarias are manipulated in practice (Mol 2002: 5) within specific contexts. In this chapter, I turn to the second aim of this thesis and focus on how and why the identities of young people are constructed. Within the arena of public health, there is a tendency to define adolescence as a distinct life-stage, the boundaries of which are largely determined by individual biology (Blum, Bastos et al. 2012). The category of adolescence is often normalised through public health discourses which privilege it as being 'biological' and 'universal' (WHO 2014). By implication, the label of adolescence thus describes a (hidden) reality which stands as a proxy for experience. I start this chapter with a discussion of how problematic this kind of conception is when applied to the Palawan setting as biological definitions of identity represent only 'partial pictures of what is under examination' (Lock and Nguyen 2010: 93) and ignore the way in which identity is also enacted through practice in different social fields (Bourdieu 1977). Rather than trying to pre-define a category that explains *a priori* what people *are* and how this identity then *determines* what they do, in this chapter, I start with the *practices* of young people in the Palawan setting. I show how young people enact different modes of both *being* and *doing* in certain contextual fields through practice. According to young people, they build, maintain and deconstruct various kinds of relationships with others across time and space within three major fields: the family unit, the marriage unit and school. It is through this processual act of relationship building that young people construct both the 'self' and what the self does.

### 8.1 Adolescence: a universal biological category?

The early 20<sup>th</sup> century saw the establishment of a new social category – the adolescent. The publication of American psychologist Stanley Hall's (1904) book, *Adolescence: Its Psychology and its Relations to Physiology, Anthropology, Sociology, Sex, Crime, Religion and Education* defined a new biologically determined developmental phase characterised by turbulence and consisting of periods of *sturm und drang* (storm and stress). For Hall, turmoil was a universal feature of adolescence. Since then, adolescence

as a category has been a distinct area of scholarly and scientific research interest. For social theorists, Hall's work encouraged anthropological and sociological critiques of the taken-for-granted homogeneity of experience assumed in analyses such as his and universalizing concepts. Seminal works that began to challenge such ideas include Margaret Mead's *Coming of Age in Samoa* (1928). Here, Mead (1928) concluded that 'adolescence is not necessarily a time of stress and strain, but that cultural conditions [in some societies] make it so" (ibid.: 234). In doing so, she established the idea that the creation of the category of adolescence is determined largely by culture, as opposed to biology.

Despite the recognition of these issues in scholarly work, in public health, there has been an increased focus on adolescence as a distinct and universal period of life (Blum, Bastos et al. 2012) that has a firm biological basis. For example, the World Health Organization (WHO) identifies adolescence as:

'the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to 19. It represents one of the critical transitions in the life span and is characterized by a tremendous pace in growth and change that is second only to that of infancy. Biological processes drive many aspects of this growth and development, with the onset of puberty marking the passage from childhood to adolescence. The biological determinants of adolescence are fairly universal; however, the duration and defining characteristics of this period may vary across time, cultures, and socioeconomic situations.'

(WHO 2014)

Although these approaches acknowledge that culture has a role, it is relegated to defining how the biological reality of adolescence is acknowledged and manifests in different social contexts. In other words, the WHO posit that adolescence is a neutral biological fact, *recognised* differently because of culture. This is exemplified in the idea of risk that is associated with this life stage in many areas of public health. The argument is often framed to suggest that because young people are in a state of progressive psychological development, they are more sensitive to a variety of social or environmental inputs or influences that make them act in risky ways (Mulye, Park et al.

2009). The idea that adolescence is based primarily in biology fails to recognise how biology and culture dialectically mediate each other. To demonstrate this, I describe how, in the Palawan context, biological aspects like age, puberty and psychological changes are not regarded as being meaningful in forming the identity category of adolescence in the way described in the WHO's definition given above. In fact, there is no identity category that aligns with these biological characteristics at all. Rather than this implying that different cultural actors recognise (or fail to recognise) biological facts in different ways, I argue that this evidence shows how, following Lock et al., (2010), biomedicine represents a 'regime of truth' that does not take account of local biology. Lock et al., (2010) define local biologies as 'the way in which biological and social processes are inseparably entangled over time, resulting in human biological difference' (ibid.: 90). The universality of the biological adolescent body, propagated through public health discourses, is therefore misleading and obscures the importance of 'biosocial differentiation' (ibid) in creating locally situated persons. Consequently, like other identity categories such as race, adolescence is not so much based in biology but an idea that has been *ascribed* to biology (Goodman 2003).

#### ***8.1.1 Adolescence as a distinct age category?***

When I began talking to people in the field, it became apparent very quickly that there was no clear translation of the term 'adolescence' into Palawano. My translator would either use the English word or specify the age range I had told him I was interested in (10-19 years old). This left most participants confused or asking for more clarification. The lack of category based on biological age is understandable as, for the Palawan, it has little relevance. In the Palawan setting, age is determined relative to natural phenomena like trees, rocks, rivers, etc. or historical events anchored in collective memory such as presidential terms or world wars. Recent developments over the last decade in health care and education have led to biological age being registered (e.g. at birth and death) and monitored and, as such, has been made more meaningful. However, many Palawan, particularly older members of the community, continue to refer to their relative age (e.g. '*I am as old as that coconut tree over there*' or '*I am the younger brother of x*') or have trouble giving an answer to what their age is at all.

It has long been recognised in scholarly work that age is influenced by social definitions and social structures (Bengtson, Putney et al. 2005) and that biological age has the

strongest significance in communities that are part of ‘modern’, industrialised societies (Keith, Fry et al. 1994). In the Palawan setting, as discussed further below, life events (that are not necessarily contingent on biological ones like puberty, menstruation etc.) such as marriage determine a person’s life stage progression from being considered a *subur* (Palawano for male unmarried child) or *budjang* (Palawano for female unmarried child) to becoming *asawa* (Palawano for husband or wife). After the birth of a first child, Palawan men and women are technically entitled to be referred to as *maman* (Mister) or *minan* (Madam). However, as described below, it is only usually elder members of the community who are addressed in this way. While biological age is less important in terms of defining a person’s distinct identity category in the Palawan setting, it is significant in establishing one’s relative identity to other people, especially within the family unit where this is an important identity marker (as described in more detail below). Respect for elders is deeply rooted in Palawan culture and provides a guideline for the hierarchy of relationships between siblings and wider group members. In this setting, ‘Ego’s generation commands a distinction between *ukaq* (Palawano for older) and *ariq* (Palawano for younger) siblings and first cousins’ (Macdonald 2007: 70). This is also widespread throughout the Philippines and is reflected, for example, in the customary gesture of lifting an older person’s hand to one’s chest or forehead upon greeting (*pagmamano* or *mano po* in Tagalog). Similarly, the use of Tagalog terms of respect such *kuya/ate* (literally meaning older brother/sister) and ‘*po*’ at the end of sentences is the *modus operandi* when addressing elders. Looking for adolescence as a distinct age category is therefore problematic in the Palawan setting where ‘the walks of life’ as one respondent referred to it, are ‘not the same as in [other] countries’.

### **8.1.2 Puberty as a marker of the transition into adolescence?**

According to Macdonald (2007), the Palawano word *sangpet* is used to denote a young person who has reached sexual maturity but it is not a term that I found was in regular usage. For girls, sexual maturity is predominantly marked by the onset of menarche and for boys, the act of being circumcised at around the age of 12. In the WHO (2014) definition of adolescence given above, the biological process of puberty is said to mark ‘the passage from childhood to adolescence’ (ibid.) but in the Palawan context, whilst menarche and circumcision are recognised, they do not mark the transition into a new developmental stage *per se*. Rather, these stages contribute to different modalities of

being a *subur* (Palawano for male unmarried child) or *budjang* (Palawano for female unmarried child) or *asawa* (Palawano for husband or wife). Young people expressed sexual maturation as part of *magdedekla* (Palawano for growing up) but did not necessarily see this as an essential part or 'rite of passage' (van Gennep 1960) in transitioning between categories.

For example, in a focus group with eight girls aged between nine and 16, all of whom had experienced their first menstruation, half still regarded themselves as *budjang* whilst the others felt they are not as they are 'grown up already'. In a focus group with 5 boys aged between 10 and 14, all considered themselves to be *subur*. Interestingly, boys did not mention circumcision as one of the factors that contributed to their sense of being a *subur* or not and it was only brought up by girls. As I did not ask direct questions about menstruation or circumcision to either boys or girls, the lack of reference may simply have been due to embarrassment on the part of boys who felt reluctant to raise such issues. However, it could also indicate the lack of significance that circumcision has in terms of conferring developmental categories. When people do talk about circumcision, they articulate its significance as a practical desire for 'cleanliness' that is associated with the practice. Furthermore, circumcision is widely practiced all over the Philippines, not just amongst the Palawan. I did not witness, nor hear of, any specific rituals related to circumcision within the community. In fact, the rise of public health practices in the area means it is now offered as part of formal 'medical missions' and is not a specifically Palawan 'cultural practice'. As one girl articulated in a focus group discussion, 'everyone [boys] must be circumcised at the age of 12 otherwise you do not belong'. Circumcision seems to be more significant in terms of its impact on wider social inclusion and cohesion: becoming clean is a necessary part of being Filipino. It has less significance as a transition into a special developmental phase of adolescence or even as a necessary marker in terms of no longer being a *subur* or *budjang*.

As discussed below, marriage is the most significant factor in culturally determining someone's transition into different identity categories. Puberty is not a condition for this transition to take place. In Palawan culture, young people can be married at any age, irrespective of puberty. Becoming an *asawa* (Palawano for husband or wife) is therefore not contingent on sexual maturation. For girls, there is a high cultural value

placed on virginity before marriage but many unmarried *budjang* do engage in sexual relationships with unmarried boys. Similarly, although having children, and hence fertility, is firmly within the field of marriage (and therefore being an *asawa*) many unmarried *budjang* become pregnant before marriage.

For boys, their readiness to get married and therefore transition into another identity category is, again, not grounded in sexual maturation, but their economic ability to support a new family as one parent explained to me:

‘The most important thing is that they have a job and are earning. That’s what the parents look for. Will he be able to support his family? If yes, then yes, they are welcome’

*Male parent*

Although menarche and circumcision are recognised in Palawan culture as being significant in changing the way in which young people both feel and act, I argue that this change is still within the realms of the culturally defined categories that align with being socially recognised children (*subur* and *budjang*) and adults (*asawa*) and do not necessarily confer positionality within a particular category nor transition between them.

### **8.1.3 Adolescents as autonomous individuals?**

The conception of adolescence in public health discourses is often framed around the idea of a transition period where children gradually develop psychologically into autonomous adults who are able to exercise increased control over their own decisions as they become more able to understand the complexity and implications of their actions. Consequently, adolescence is described as a particularly risky period as young people are still developing cognitive faculties that allow for these processes. Therefore adolescents are considered more likely to engage in ‘negative’ or ‘risky’ behaviours. This is illustrated by the WHO (2014) definition of adolescence:

‘Adolescents are different both from young children and from adults. Specifically, adolescents are not fully capable of understanding complex concepts, or the relationship between behaviour and consequences, or the degree of control they have or can have over health decision making’

(ibid.)

In line with this, there has been a plethora of recent research on the ‘teenage brain’ that examines the role of environmental influences on the structure, biochemistry and function of young people’s brain function in the fields of psychology, neurobiology, genetics, neurology and psychiatry (Casey, Kosofsky et al. 2014). However, this emphasis on the individual cognitive acquisition of psychological factors like complexity, consequence evaluation and control fails to take account of the equally important culturally situated and constructed nature of these faculties.

For example, in a communal and relational culture like that of the Palawan, decision-making practice is embedded within a deeply rooted consensual, process-oriented system. Decision-making is collective and occurs within the bounds of the family, marriage and wider community unit. Far from being recognised as a predominately *cognitive function* of the individual, it is regarded as a *processual act* of the group. Youth is not considered a time to develop an identity and role separate of the group but to forge one’s role *within* it. This is explored in much more detail below as well as in chapter 10 (in discussions about self-esteem and self-efficacy) but here it is important to establish that shifting the focus on control over decision-making away from individual psychological development and onto communal social practice does not strip individuals of their agency, nor their perceived sense of agency.

Anthropologists have contributed much to the theorization of personhood including distinguishing between notions of ‘individualism’ and ‘individuality’:

‘individualism pertains to a particular historico-cultural conceptualization of the person or self, and might include: notions of the ultimate value and dignity of the human individual, his or her moral and intellectual autonomy, rationality and self-knowledge, spirituality, voluntary contracting into a society, market and polity, the right to privacy and self-development . . . Individuality, by contrast, refers to the universal nature of human existence whereby it is individuals who possess agency’

(Crankshaft-Publishing 2014)

In the Palawan setting, the notion of individualism is not present in the same way that it is in many Euro-American contexts. Consequently, the notion that young people universally ascribe to or desire individualism is problematic. Young people rarely express individualistic sentiments and similarly seemed puzzled when I asked them about them. However, independence or the ability to make or act on decisions alone is not the same as self-determination or individuality which can be defined as the ability to make or act on a decision congruent with one's *will* (ibid.). Young Palawan people expressed how they negotiate their agency and will in many contexts through a variety of means. The following examples, the first from a young girl and second from a young boy, illustrate this:

'Once, I wanted to go to a wedding ceremony alone, with no companion. I asked my parents and they said "no" but I kept trying and eventually I was allowed to go alone. If you are unmarried you can sometimes go to things without your parents but you always have to have a companion so it was a big thing for them to let me'

*Young Palawan girl*

'Sometimes we will practice little by little, especially if you are a boy. I can practice my authority in things I want. Like if I decided to have a cigarette. So even though my father says 'no you are too young' I practice to smoke even without his permission and then later, little by little I show him, to prove I am improving in doing what I want'

*Young Palawan boy*

Parents too, recognise the self-determination of their children and employ various strategies to negotiate their autonomy. As one father explained:

'We do something when children fight with their parents. We get a cooking pot which is hot. When the water is boiling we put it on the child's legs and see if he can tolerate that. If so, then you are allowed to be separated from your parents or fight with your parents. If not, you cannot. We do this for children who fight with their parents'

*Male parent*



Autonomy in the Palawan context manifests through collective interdependence which does not exclude the possibility of individuality or self-determination. While this might coexist with a lack of a developed sense of individualism, this does not mean young people cannot and do not exercise their agency. In this context, it may be more useful to think of perceptions of the self as pertaining to: relationalism rather than individualism (Robbins 2002); dividuality rather than individuality (Strathern 1998) and heteronomy rather than autonomy (Sariola and Simpson 2011). This has implications for the way in which we think about Palawan people's own sense of the control that they have in their lives – what is usually referred to as notions of self-esteem or self-efficacy. These notions have direct relevance to the agency young people have in promoting health and will be discussed in much more detail in chapter 10. For now, I will look more closely at how instrumental the cultural, and not just biological, world is in forming identity.

## **8.2 Growing up in Palawan society - the enactment of relational identity**

Above, I have suggested that essentialist, biologically-based definitions of 'adolescence', as articulated in public health discourses, may be problematic in this particular setting. Below, I document the practices of young people in the Palawan setting and show how these practices themselves structure different modes of both *being* and *doing* in certain contextual fields. In doing so, I adopt the theoretical framework of social constructionism which stresses, amongst other things, the communal/relational way in which reality is created and, accordingly, the significance of relationships and relationality in the construction of the self and identity (Strathern 1998; Robbins 2002). This approach also aligns with the 'anthropology of childhood' which has now emerged and, in Britain in particular, constitutes ethnographies *with* (as opposed to *on*) young people. Within this approach, young people are included as active participants and universalising categories like childhood, adolescence and adulthood are interrogated in light of indigenous notions (Christensen and Prout 2005). As described below, the analysis of young people's lived experience illuminates the way in which relational identity is formed through practice within various social fields. Young people's identities are structured through the formation of relationships across space and time in three major multi-dimensional settings which I go on to explore in the remainder of this chapter: the family unit; the marriage unit; and school.

### 8.2.1 *The sangkesawanan (family)*

As described in chapter 2, traditional Palawan settlements are based on *rurungan* (neighbourhoods) or *sang keperurungan* (one unit of neighbourhood) made up of individual *bena* (households). The *bena* is one of the principal stable social units in Palawan society and is therefore integral to the way in which relational identity is formed. Macdonald (2007) explains how, within the Palawan conception of the *sangkesawanan* (family), there is a distinction between the nuclear family which is comprised of parents and offspring and the extended family which includes all bilaterally recognised kin within the first degree of cousinship and centred on the siblings (ibid: 73). It is these two circles which have an essential role in ordering social relations as illustrated by the following example taken from my own findings.

Dowit and Lina are brother and sister. Dowit is a 13 year old boy and in Grade 5 at school and Lina is an 11 year old girl and in Grade 3 at the same school. They are the second to youngest and youngest respectively of their parents' seven children. Their oldest sister has five children and her third child, Arnel (Dowit and Lina's nephew) also goes to the same school as Dowit and Lina. He is 12 years old and in Grade 4. All three children were part of the photovoice project and I got to know them well. Dowit and Lina live with their parents in a house just next door to Arnel and his family. All three think of themselves as children (either *subur* in the case of Dowit and Arnel and *budjang* in the case of Lina) and they evidence this by things like the obvious fact they are not married but also because they spend a lot of time playing and do not have to do domestic tasks like their parents, mostly because they are still unmarried and able to attend school. However, they do recognise that they are *magdedekla* (Palawano for growing up) and, as such, are required to help their parents with some domestic activities in the home. As the two youngest siblings, Dowit and Lina spend a lot of time within the shared spaces of school and home. At home, Lina helps her mother with things like cooking and washing dishes while Dowit helps with tasks like fetching coconuts, burning the rubbish and carrying bags of rice. In this way they are beginning to perform gendered roles consistent with their own expectations and what is expected of them. They have come to do what males and females 'should' do in the house through a mixture of 'observing their parents' and by 'being told by them'. Similarly, in play, Dowit and Lina tend to be increasingly separate and there is a gendered element to this.

Lina likes to play with her female friends and relatives who live nearby. They play a variety of games including one where they use cut-outs of people and objects from magazines to construct families and life plots. Dowit plays with other boys including his nephew Arnel. They spend their time engaging in activities which according to them are 'more for boys' like tree climbing and a coin tossing game which they describe as a form of gambling. However, Lina also likes these kinds of games and frequently asks her older brother and nephew if she can join in with them and 'sometimes they say it is ok'.

There is a certain level of symmetry between these children in their performance of activities that they associate with their lives as children. However, there are two major aspects that determine a hierarchy in their relationships - their relative age and generational relationships. As Dowit is the eldest sibling, Lina refers to him as her '*kuya*' (Tagalog for older brother) and uses '*po*' to address him as a sign of respect. Lina defers to him before doing many things including engaging in practices that relate to health. During the photovoice sessions she explained:

'I do not take medicines without asking somebody first. I always ask my older brother Dowit. Dowit doesn't always know which medicines to take but I have to ask him so that he doesn't get angry and strike me. In my opinion it is important to always ask permission from older people before taking medicine'

In response to this, Dowit admits he doesn't always know what appropriate medicines to take and will in turn ask one of his parents or older siblings for advice:

'I always ask older ones in the house or my parents before doing things, especially my father. He is the one who tells us what to do. Even my mother must seek his advice. We cannot do things alone'

However, for Dowit too, it is still important that his younger sister asks his permission before engaging in practices like taking medicines. Here, his knowledge, biological age (he is after all only 2 years older than Lina) or decision-making faculties are not as important as his *relative* status to Lina in terms of defining their roles and practice.

While relative age is an important factor in determining practice, generational relationships are arguably more important. Although Arnel is biologically older in years than his aunty Lina, he still recognises the need to ask his '*tita*' for permission before

conducting many activities including those that relate to health. However, Arnel feels caught between the recognition that he should ask Lina before doing things because she is his aunt and the fact that he is relatively older than her and therefore, more significantly in the school setting, in a higher grade than her. This puts Arnel in a difficult position within the context of school. Consequently, in this field, he subverts the normal order of things by supposedly 'doing things without always asking her'. However, in sessions, I observed that when Lina scolded Arnel, although giving an impression of ignoring her in order to establish his defiance in front of his classmates, he still ultimately obeyed Lina's chastisement. In doing so, through practice, he adheres to and contributes to the re-enforcement of Lina's superior social role within the family unit as his aunt, despite her lower biological age and grade.

The family unit is an important field in which young people form sets of relationships that enact both their identities and practices. Far from this process being one that centres around the individual, people see themselves as acting within a unit. The maintenance of this unit relies on its constituent members working together and ultimately forms the basis for people's feelings of wellbeing. This was articulated by one of the young people in a photovoice session prompting a discussion in which participants emphasised the importance of the family unit as a whole:

'Participant: That's my mother putting up the laundry, exposing it to the sunlight. She puts the clothes up that belong to my father and my sisters in the sunlight.

Me: Why did you take this picture?

Participant: To show industriousness – working together. It is good to help [each other] in the family . . . I wash clothes, help looking after my brothers and sisters. It is important to help look after each other.

Me: Why?

Participant: To be happy and healthy'

*Haliya, female participant*

Within the family unit, young people re-create their sense of being by engaging in practices in relation to other members of the family. Dowit, Lina and Arnel are at once

children through playing with each other but are *magdedekla* (Palawano for growing up) through their increased engagement in domestic tasks with their parents. While gender is less relevant in determining practice amongst younger children, compared for example with the marriage unit, through a mixture of what young people describe as 'observing' and 'being told', they increasingly re-enforce gender through activities which they enact like domestic tasks and games. However, these roles are neither essential nor fixed. Lina demonstrates this by exercising her will to play games that are 'more for boys' with her male relatives.

Young people's enactments of their identity are also characterised by the performance of relationally hierarchical relationships that help define and create who they are within the family unit. At the top of this order are parents, particularly fathers. This order is brought into being by young people through their deference to their parents in terms of decision-making. However, rather than this being a structure imposed onto young people, children help to re-create this situation through their everyday practices. In fact, young people and adults desire *inter-dependence* with their parents. This sentiment came out very strongly during interviews and focus group discussions with both groups. For example, in a focus group with young, unmarried school girls, all participants expressed the view that they did not want to be independent from their parents either spatially or in terms of control over decision-making:

'From childhood we grow with them so we don't want to separate from them. Even if we are married we don't want to leave. We will build our house just there, next to them'

*Aisel, female participant*

'It's different in other places. It's not bad to want to separate from your parents but it's not for us, this is *our* thing'

*Clarsima, female participant*

Unmarried school boys also expressed the same sentiments in a focus group:

'We don't want to go away because we can't stand on our own. We need our parents always'

*Jepoy, male participant*

‘We ask our parents before we do everything’

*Welson, male participant*

‘Our parents’ decisions are better than ours’

*Michael, male participant*

As explored further below, even after marriage, the predominant cultural marker of a transition to adulthood, there is an extended period of dependence on parents and elder family members. Married adults cohabit with parents and still rely on these relationships when it comes to decision-making. Older, married adults too expressed the same feelings about their relationship with their own parents. Markers of adulthood like marriage therefore do not exclude the need and desire to consult one’s own parents:

‘Everyone always has to ask their parents. It doesn’t matter if you are married or not married. Even till the age of 40. Always, you have to ask your parents’

*Male elder*

As well as with their parents, young people also enact relationally hierarchical relationships with each other. Lina addresses her older brother with the respect implied in *kuya* and *po* and re-creates his authority over her by asking his permission before enacting her own practices. Dowit similarly reproduces this situation through his reprimanding of Lina when she does not ask his permission. Again, roles and identities are not fixed: Arnel feels caught in the middle of a variety of shared understandings and meanings. Although there is a shared understanding that Lina is socially higher as his aunt, she is, outside of the context of the family unit and in the realm of school, structurally ‘below’ him by nature of being in a lower grade. Consequently, he creates a situation where he is at once inferior and superior to her. In some situations in school, he supposedly does not always ask her permission, asserting his dominance as someone

'higher' by nature of being in a higher grade. This undermines Lina's superior status but he does this in order to maintain his status in relation to friends. However, Arnel simultaneously complies with her reprimands when she gives them in order to maintain his relationship with her as his aunt.

Within the field of the family unit, roles and identities are not defined by *a priori* categories like age, gender or adolescence, but instead are created through the dynamic enactment of practice. In the example above, Dowit, Lina and Arnel all define themselves as children (*subur* and *budjang*) but they are different kinds of children at different times and for different reasons. They construct what it is to be a child in various situations through their maintenance of various social relationships in relation to other members of their family.

### **8.2.2 The marriage unit**

Within the Palawan setting, marriage is the most significant cultural field in which young people deconstruct and construct various relationships that mediate both their identity and practice. Marriage is something that all young people I spoke to talked about and for the vast majority, was something that they strongly valued. For example, Christalyn is typical of many young, married women I met. She is a 16 year old girl who is ethnically Palawan and refers to herself as an *asawa* (Palawano for husband or wife) since she got married. Although she had completed some grades in Elementary School, in 2008, she stopped going to school due to her family's lack of money and the long 14 km journey she had to walk every day. Her father instructed that she could no longer go to school and requested her to remain at home. For Christalyn, as a *budjang* (Palawano for female unmarried child), her life was 'carefree'. After she stopped going to school, she spent her days carrying out some domestic tasks in the house like washing the dishes, sweeping the surroundings and caring for her younger sister when her mother would ask her to. However, as she was still unmarried, she was also largely free to go wherever she wanted and to socialise with whomever she wanted to. Although her parents forbade her to have romantic relationships with boys, she met a boy from a neighbouring village called Jonathan. They spent time together 'just walking along the way' or 'going over there' and entered into a sexual relationship without the knowledge of her parents. After a few months, the couple approached Christalyn's parents together to tell them that they wanted to get married. Her *lolo* (Tagalog for grandfather), who is

also a *panglima* (Palawano for leader), sat down with the young couple to establish how serious their request was. Following this conversation, the couple's parents met privately to discuss the situation and agreed to the union.

Following her marriage, Christalyn no longer considered herself a *budjang* because she was now part of a *mag-asawa* (Palawano for a married couple). Now, she still lives in her family home with her parents and younger sister but her husband also lives in the house with them. Although uxorilocality (matrilocal residence) is the convention, Christalyn and Jonathan have other plans: they are in the process of building their own house down near the highway in an area that is owned by and located near to Jonathan's parents. Christalyn is reluctant to move away from her own family as this is not the 'way' things are usually done. Since getting married, Christalyn feels her life has undergone a 'big change'. Her daily life consists of waking up at 5 am and preparing breakfast for her husband who usually goes to work doing *arawan* (wage labour). She spends the rest of the day doing chores like sweeping, washing clothes and dishes and cooking meals for her and her husband. Even if she was financially able to go to school again she would not because she would feel 'ashamed' in front of her single friends because now she is 'different'. She describes her life now with some sadness as it is 'not like it was before'. Firstly, she is no longer free to go anywhere she wants and to socialise with her single friends. Instead she feels she is 'limited'. If she goes out then her husband says to her 'you should be at home'. She fears that if she goes out too much, it will affect her 'newly formed house'. Secondly, she now has to 'serve other people' - her husband and in-laws, not just her own parents, which is a big change. This will also be the case if she moves to live near Jonathan's parents as she will be directly 'under them'. The third issue for Christalyn is that she has to deal with 'love quarrels' and problems of jealousy between her and her husband. For her, there are many things she did not used to care about before but now she feels 'heavy with responsibilities'. Despite this ambivalence or even negativity towards married life, for Christalyn, marriage is still very important. Finding a companion and getting married was something she wanted to do for a long time and she enjoys caring for her husband. Her long-term plan is to have children so that she can build her own family.

The example above illustrates how significant a transition marriage is within the Palawan developmental cycle. In cultural terms, marriage and the wedding ceremony



constitute a rite of passage (van Gennep 1960) for both males and females from being a child (*subur* (m) / *budjang* (f)) to becoming an *asawa* (Palawano for husband and wife) who are now joined together as a *mag-asawa* (Palawano for married couple). Apart from marriage, there is no other coming-of-age ceremony for males and females and a person will remain a *subur* or *budjang* until they are married, regardless of biological age or puberty. People often joked with me that although I was older in years than many of the young people I was interested in, I was in fact 'lower than them', being unmarried myself. Having children also represents another structural factor that affects one's status in society. After the birth of a first child, Palawan men and women are technically entitled to be referred to as *maman* (Mister) or *minan* (Madam). However, having children appears to be considered to be less of a significant transitional stage than getting married and I observed that it is only usually elder members of the community who were addressed in this way.

For Christalyn, the act of getting married changed the way she feels about herself and the practices she engages in for many reasons. Through marriage, young people deconstruct and construct a variety of relationships through which identity and practice are mediated. Most importantly, young married couples form new relationships with each other, as a unit. As Christalyn explained, this is a 'big change' but for many people, like Christalyn, it is still one that they desired and they expressed feelings of companionship and togetherness:

'It's so nice - when you harvest the rice, one of you will hold the stem  
and the other will cut it'

*Married woman*

'you feel . . . yes, now it is my time to be together!'

*Married woman*

'You become banded together when you are married. Two together'

*Married man*

On the whole, the Palawan marry people from within their own village or neighbouring villages. In terms of taboos, it is forbidden to marry first cousins, aunts, uncles, grandparents, parents, or siblings. Any taboo relationships result in *sumbung* - a curse on the whole community such as too much sunlight, heat or rain brought about by the *tandayag* – a giant fish like creature living in the sea. In terms of deciding to form a union, in the past, Palawan marriages tended to be arranged for young people by parents through *panglimas* (Palawano for leaders) and children could be as young as 8 years old. As one participant explained:

‘Before, we didn’t know each other so our parents had to negotiate [for us] . . . but now, what’s the use? Sometimes young people are even pregnant before they marry’

*Male elder*

Now young people, like Christalyn, commonly have sexual relationships, even without the knowledge of their parents, and in doing so, subvert so-called cultural ‘traditions’.

The new unit that is formed as a result of becoming part of a *mag-asawa* (Palawano for a married couple) also requires reconfiguration of existing relationships. Old relationships with single friends are dismantled as married people feel themselves to be, as Christalyn articulated, ‘different’ from them. Perhaps more significantly, as described above, the nuclear family unit is the primary field in which identities play out for young people but this also changes through marriage as newlywed couples reconfigure their relationships with their own parents. Through marriage, both men and women exchange their hierarchy of respect so that their highest respect transfers from their own parents to both their in-laws. As one newlywed woman explained:

‘Your mother-in-law becomes more important than your own mother. For example, when your natural mother calls you, it’s ok if you don’t answer but if your mother-in-law calls you then you must answer. If you don’t, you will have *busong* – you will endure a lot of curse’

*Young married woman*

A young married couple will therefore still have to consult with and answer to in-laws, particularly fathers-in-law, regarding many everyday actions and decisions. This has

significant implications for the practices that concern health as one young married man explains:

‘Before, when I would get sick, I would tell my parents, mainly my mother. She is the one who would prepare for me some medicine or take me to the *albularyo* [Tagalog for herbalist]. Now, when I get sick, I must consult with my father-in-law before doing anything. He is the one who will advise me. If I need money for the tricycle or for medicines, I have to ask him’

*Young married man*

As well as reconfiguring social relations, marriage also reconfigures the space or fields in which young people enact their identity and practices. Christalyn will soon be separated from her existing family unit through moving to a new house. As described in chapter 2, following marriage, men are traditionally the ones who move to the bride’s house or, more commonly, will be granted a piece of land nearby to build their own house as well as an area further up the mountain to establish their own swidden *kaingin*. Women, namely sisters, join the community together and in-marrying men are said to ‘stick’ (*-pikit*) to their high status, wife-giving, fathers-in-law (Macdonald 2007). In this case, Christalyn is defying this convention by moving to live near her husband’s family, thereby spatially separating herself from her nuclear family.

As well as separating from her own parents, Christalyn is now also separated from her single friends. As she said, she feels she is restricted in terms of what she can do, where she can go and who she can mix with and recreates her identity as a married woman by ‘limiting’ where she goes. This absence of freedom and a sense of feeling carefree were expressed by many young people who got married. As this young man explains:

‘You cannot do many things like visit your neighbours or go out too much because it’s not like when you are single and free. When you are married it’s limited. You have work in the house and also you are considering your husband or wife’s feelings. Your parents and in-laws tell you not to do things and not go to places’

*Young married man*

Within the field of marriage, men and women also separate spatially through their performance of increasingly gendered roles and feel that there are heightened expectations for socially responsible behaviour. Women tend not to earn money for themselves through work and tend to remain in the home and, like Christalyn, perform largely domestic activities. Many women explained that when they do go out it is not anywhere far from the home and usually just to their neighbours or family members' homes. They spend much of their time with other married, female friends and relatives. Men on the other hand, are expected to earn a living, mostly through daily wage labour or working in the swidden *kaingin* fields, taking them further away and usually in the company of other married men. As a result, when Christalyn is sick, she has access to only certain kinds of people (married women) and resources (home-based care) and tends to wait for her husband or parents to return home before taking any action that would require her to be accompanied somewhere (for example to travel to the health clinic) or to have money (to buy medicines). Conversely, men, like Christalyn's husband Jonathan, have access to a much wider range of services by nature of their work which takes them into the town and the social freedom they have to travel alone, as well as access to their own money that they earn through employment.

Another major spatial implication of getting married for both men and women is that they will no longer attend school. The idea of shame incurred by married people who go to school was a common theme amongst both men and women that I spoke to and it was explained as being due to the embarrassment associated with sexual relationships that are implied in marriage. As this respondent explained:

‘There is no-one who is married who has continued with school [all the other women around are laughing a lot and look embarrassed]. For example, if your classmate is single and you are married then she will tease you and say ‘you are old and married’ and so the next day you won’t go. You are different now so everyone will look at you and so you feel you are being burnt in that environment. It’s impossible – it’s a fear for you to go to school if you are married’

*Married woman*

Furthermore, sexual relationships confer feelings of jealousy. Like Christalyn, many couples said that something that set them apart from their single peers was ‘love

quarrels'. When couples struggle to resolve issues and can no longer 'endure the situation' they will often consult with their parents/in-laws for advice. In extreme cases, the issues are taken to the *panglima* who is tasked with 'observing and judging' the situation. In some cases, divorce is granted and the return of the dowry agreed if necessary (for example if the wife was found to have committed adultery). In order to try to avoid quarrels, people spatially separate themselves from members of the opposite sex:

'You are no longer entitled to sit with a male or female. When you are in school you can sit with boys and girls but when you get married you cannot mix. You really have to behave'

*Male elder*

Many young people like Christalyn engage in sexual relationships before marriage and thereby subvert the social convention that links this with the field of marriage and adulthood. However, sexual relationships, or at least those that are discovered or result in pregnancy, usually lead to marriage suggesting that through their actions, people do continue to perpetuate this cultural norm.

Together, these factors illustrate how significant the act of marriage is in terms of forming both a young person's identity and their practice. In terms of health-related practice in particular, being married requires young people to dismantle and construct a range of new relationships which, in turn, affects both their identity and the decisions that they make concerning their health.

### **8.2.3 School**

As well as the family and marriage unit, young people's narratives about their lives reveal that, for those that attend school, it is another major field in which social relations are enacted. For example, Jeverlyn is an unmarried 14-year-old Palawan girl in Grade 6 of Elementary School. She enjoys going to school and has aspirations to continue on to complete High School and College. After that, she wants to become a doctor so she 'can help sick people':

'When my grandmother was sick I went with her to the hospital in Brookes Point and met a nice female doctor who was tending to my grandmother. When I saw the doctor I decided I wanted to be a doctor

like her so that if my grandmother is sick again then I can help her and any other people in the community'

Jeverlyn is not interested in getting married at her age even though it is something her parents did as, for her, because of school; it is not the 'proper time' and so she is 'not thinking of those matters now'. Instead, marriage is something she associates with women who are in their 30's who have already finished their education. Instead, Jeverlyn is fixed on fulfilling her 'own dreams' of finishing school. Jeverlyn does not want to stay in the house like her mother. Although she helps her mother in the home, she finds school more interesting. She acknowledges that she learns 'new and different things' in school that her parents do not know but feels these things can ultimately help her to get a job that will help her and her family. She explains that her parents work hard so that they can earn money for her school fees and in return she works hard at school. She sees education as a means to 'upgrade' her life and that of her parents.

At 15 years old, Jeverlyn considers herself to be 'grown up':

'I am free to go around together with my friends. And even now, I have my own mind and thoughts . . . My parents have started to treat me differently. When your parents think you are a child, they can spank you in front of many people but if you are grown they will not spank you and maybe they will respect you'

In general, Jeverlyn is very happy with her life as a young person. She enjoys the freedom she has to go around with her friends from school, 'talking about many things like crushes [on boys]'. Most of all, she is happy that she lives in Bataraza. She doesn't want to live anywhere else because '[her] life is here'. When I ask her what she would like to tell other people about her life, she says that she loves to live in the Philippines which is a beautiful country and would like to 'tell every other person that if they have any relatives in the Philippines then they should come live here too and they will be happy'.

Current education in the Philippines continues to follow the system of free public schools initiated by American colonisers in 1901. An increased emphasis on the mainstream education of Indigenous Peoples (IPs) has been made by the National Government in recent years and in Bataraza this has seen the establishment of a

number of public elementary schools in remote areas over the decade. This has meant that more and more IP children are attending government schools in contrast to their parent's generation. For young people like Jeverlyn, school is an important field in which the construction of her sense of self takes place. Through going to school, children like Jeverlyn form many new relationships with other school children and teachers that allow them to make new associations that differentiate themselves from their parents and other out of school (i.e. married or poor) youth, who for them, represent 'traditional' ways of life.

As well as forming new relationships which help form their sense of identity, school children also engage in different kinds of learning and acquire different kinds of knowledge and skills that also set them apart from other community members. Going to school means Jeverlyn cannot be at home to perform many domestic tasks like her mother and instead learns 'new and different things' at school which she feels will help her to construct a very different future for herself compared to that of her mother. This includes not performing culturally-normative activities like getting married young and staying at home to conduct domestic tasks. Engaging in a process of acquiring knowledge and having her 'own mind and thoughts' contributes to Jeverlyn's sense of no longer feeling like a child, as opposed to life events like marriage that contributed to Christalyn's. These sentiments were very common amongst all of the young school students I spoke to who wanted to break with 'tradition' in terms of the kinds of knowledge and ways it was acquired compared to their parents. The kind of knowledge they gained at school and the system of learning is desirable to young people as it will help them to work in 'white collar' jobs as opposed to earning a living through farming, fishing or conducting wage labour like their parents. In focus groups, young school girls said they wanted careers such as doctors, nurses and office workers and boys said they hoped to join the police, marines or army. Many children expressed their desire to become teachers, inspired by their own teachers at school. Older Palawan members of the community feel many changes have taken place in their society in relation to young people's lives as a result of school and see them as very different to their own. While some lament the loss of what they describe as 'indigenous ways of life', which has resulted from the increase in school attendance, on the whole they view these changes as very positive and as a sign of 'progress' and 'civilisation'.

Similarly, children are learning new kinds of knowledge compared to their parents or elders in the community. This 'new' knowledge is gained quickly and is very distinct from generational knowledge that had taken years to develop. This is particularly the case in terms of knowledge and practices that relate to health. Many older people that I spoke to are concerned about how certain Palawan cultural practices will be preserved and the implications this will have for how 'native' diseases can be treated in the future. However, many young people that I spoke to in school had little interest in learning about herbal medicines or 'traditional' practices. Jeverlyn, for example, was much more interested in focussing on the knowledge and skills she would acquire in school that would help her to become a doctor in a health clinic. While older people are still adapting to the changes created by school, it is already having an impact on the way in which adults and young people exchange knowledge as well as the relational dynamics that govern such exchanges. As one father explains:

'People have to listen to older people because they have eaten more rice meals but it is possible to learn things from the young people. If he is teaching right things, maybe like things that they learnt in school, then it is possible to receive their counsel'

*Male parent*

Being at school also means Jeverlyn's life is played out in a different spatial field to her parents and other community members. This gives her, and others like her, a sense of 'freedom' which also characterises her sense of adulthood (as opposed to the lack of freedom that characterises Christalyn's now that she is married). The interaction that Jeverlyn has with her surroundings also elicits emotional feelings such as happiness that contribute to her sense of well-being. In focus groups, all of the young people I spoke to felt that they were very lucky to be a young person in Bataraza and had no desire to go anywhere else. They articulated this as being because of the natural beauty of the place but most of all because all of their friends and families lived there and, in consequence, this was where their lives were. For these young people, their sense of identity was very strongly associated with their sense of place. They could not be the same in another setting because they could not have the same relationships and could not carry out the same kinds of activities.



Within the field of school, young people create different modes of being. In the school setting, they learn in different ways and learn new kinds of knowledge compared to their parents and other out-of-school youth. Being in school also allows them to create different modalities of childhood and adulthood. For some like Dowit, Lina and Arnel, their attendance at school forms the basis of the construction of their lives as children as it means they do different things to their adult parents. Although those that are socially defined as adults by nature of being married both exclude themselves, and are socially excluded from school, this does not mean that some young people like Jeverlyn cannot create different modalities of adulthood in the school setting that are grounded in feelings of 'freedom' and the acquisition of 'new' kinds of knowledge.

### **8.3 Conclusion**

In this chapter, I have suggested that the biological identity category of adolescence, as propagated through public health discourses, is problematic when applied in real-life settings like amongst the Palawan. The imposition of such categories has two important implications. First, it suggests identity is primordial and exists 'out there' as an underlying reality. This ignores the central role that the social has in shaping identity. Second, this kind of conception tells us nothing useful about the mechanisms through which identity and reality are formed. By beginning with the practices of young people within the Palawan setting, I have shown how young people's identity is mediated by the processual act of building, maintaining and deconstructing various kinds of relationships with others across time and space within specific social fields. Understanding the situated, interrelational and embodied way in which identity is enacted through practice is significant because it helps to better understand how and why young people enact both the 'self' and what the self does in certain situations. Ultimately, this has implications for the kinds of interventions that can potentially be used to affect positive change in young people's health-related practices. This is crucial to the discussion in the remainder of this thesis which deals with photovoice – one such methodology that is orientated towards both illuminating but also potentially altering practice.

## Chapter 9: *Doing* photovoice as a research method

In this chapter, and the subsequent two chapters, I turn to the final aim of this thesis which is to explore how *doing* photovoice, as a method of Participatory-Action Research (PAR), can both depict and potentially alter young people's health practices related to malaria. To do this, I provide a critical assessment of photovoice in terms of its three component PAR elements - *participation*, *action* and *research*. In order to ground the discussion *in practice* itself, I will focus on the last aspect first - photovoice as a *research* method and begin with a detailed description of how the project was done. This will provide the necessary context for exploring how action and participation unfolded in the next two chapters.

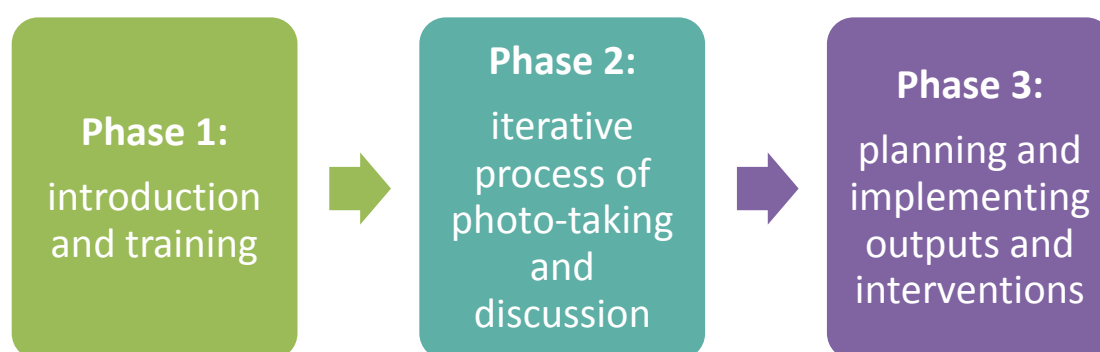
Although growing numbers of researchers have used photovoice, 'the methodological and pragmatic considerations that arise when engaging in . . . photovoice with young people are not often explored or reported' (Fournier, Bridge et al. 2014: 2). These issues require critical consideration as they have implications regarding not only the kinds of research data generated in the process (as discussed in this chapter), but also the action and change that occurred as a result (as discussed in chapter 10) as well as the way in which people participated in the project (as discussed in chapter 11). While participatory methods like photovoice have been successfully applied in many settings, the objectification and depersonalisation of experience evident in some studies presents methods as if they are standardised, repeatable, neutral experiments. In addition, the suppressed role of the author in some publications is a powerful literary technique that runs the risk of convincing the reader that, had they been there, they should have experienced what the ethnographer experienced and concluded what the ethnographer concluded (Geertz 1988). In critique of this, I will provide in this chapter, an analysis of how the specific context in which photovoice was conducted affected both the way the project practically unfolded and also the data generated as a result. These contextual factors include power and positionality, the co-facilitation process, the low-resource setting, reactions to and use of cameras and the process of conducting participatory analysis. I provide a detailed description of the adaptations and innovations that I introduced to the method in order to address some of the challenges I faced working in this particular setting. By providing ethnographic reflections on how participants and I

*did* our project together, I hope to acknowledge the *situational* nature of photovoice as a method as well as the effects it had.

## 9.1 Methods: the implementation of photovoice

I begin this chapter by providing a detailed description of the 15-week photovoice project in order to ground the discussion in practice before going on, in the next section, to discuss some of the contextual factors that affected the way the process unfolded. The project was divided into 3 broadly linear phases outlined in Figure 9.1 below:

**Figure 9.1 Diagram illustrating phases of photovoice process.**



### 9.1.1 Phase 1: introduction and training

Consistent with the literature on photovoice, the aim of initial sessions was to: introduce the project and methodology; ‘bond’ the group; and provide basic training of photography and camera use (Wang and Burris 1997; Wang, Yi et al. 1998; Wang 1999).

As I was working in two schools with 44 young people (28 students in one school and 16 in the other), I divided the pupils into five groups of around seven-10 students. Each group met once a week on a regular day for 15 weeks. In addition to myself and a translator, I asked that at least one teacher who had attended the photovoice training session that I gave was also present at the sessions to act as an additional co-facilitator.

Sessions were held in both schools, during the lunch break, between 11.00am and 1.30pm. Each session began with participants, facilitators and me eating lunch together which I provided. As well as being a practical incentive to secure attendance, as time went on, food gained more significance than I had anticipated as described further below. In this early phase, group ‘bonding’ was a central tenet. Although the participants

already knew each other from attending the same school, they were brought together in new configurations of age, gender, grade, ethnicity and relatedness. While some of the literature suggests that developmentally heterogeneous groups can inhibit the photovoice process (Strack, Magill et al. 2004), I found that mixed groups also worked well in terms of encouraging cooperative learning as different children each brought with them a variety of skills and experience.

In order to strengthen group identity, I asked each of the groups to decide on a name and each session began with one or two games which revolved around learning each others' names, getting to know each other, movement and concentration. As is consistent with the ethos of participatory research, early on, we established ground rules and group objectives together. In terms of rules, young people contributed suggestions like 'listening to each other', 'not making noise', 'not cursing', 'taking care of the cameras' and 'participating in discussion'. I suggested additions including 'good attendance' and 'having fun'. Establishing objectives was a harder task to do together early on as I felt that although young people understood the practical requirements of the project, they found it difficult to conceive of the potential of the method until a few weeks into the process. Consequently, this might have been something that was better done later on.

An important aim of early sessions was to gauge the 'visual literacy' of participants. Visual literacy is defined as 'the ability to read and understand pictures and is [considered] a basic skill for working with photographs' (Photovoice/World Vision 2011). However, in practice, this is culturally specific so it was important to assess the nature of this at the beginning of the project in order to see how it changed over the lifetime of the sessions. In order to do this and introduce the idea of photography and photovoice, the first activity I asked young people to do was to describe a picture from memory to the rest of the group. Many young people were unable to think of a picture so I also distributed printed pictures which individuals hid from each other and described. In the same introductory session, young people split into smaller groups and were given around 50-70 printed pictures which I asked them to: look through and discuss the content of together; sort into piles that represented good health, bad health and contested/unclear images; select three-five final images for a final display; and finally orally present their display to the group. These initial activities revealed a lot

about the visual literacy of the group at baseline and their knowledge of and experience of images in their lives. Some of the findings and implications are discussed below.

In the second session, I provided a very basic descriptive introduction into how cameras work and then distributed a digital camera to each child and explained, in an interactive session, the basics of holding the camera correctly, turning it on and off, positioning it, taking pictures and viewing them. Once we took and viewed a few pictures in the group, I gave young people a 'visual treasure hunt' (Blackman and Fairey 2007) to do around the school, taking pictures of things from different vantage points, or that focused on colour, pattern, emotions etc. I asked young people to select one image to show the rest of the group on a laptop so we could guess together what item from the treasure hunt we thought those pictures represented (and to illustrate the point that a picture's content or intention is not always clear). In the third session, I set up a studio of objects in the classroom so young people could practice taking pictures exploring concepts like light, vantage point, focus, composition etc. which I had discussed with them. Technical information about photography was kept purposively light in order not to stifle 'people's creativity' (Wang and Burris 1997: 378) but I felt it was important to provide some training on this in order to allow participants to have enough knowledge and skills to capture and express what they wanted to through photography. I also gave participants an exercise to do around portraiture and taking pictures of people. We discussed ethical issues of taking pictures of people including gaining consent and role-played possible scenarios that could arise when young people were taking pictures in their communities. After a brief discussion about how to care for cameras at home and how to change batteries, I set participants their first 'homework' assignment which is discussed in the next section.

### ***9.1.2 Phase 2: iterative process of photo-taking and discussion***

Once young people felt more comfortable with me, the facilitators and each other, the idea of the methodology and the equipment, we embarked on the main component of the sessions – photo-taking and discussion. The first assignment I set young people was to explore the question, 'how do you stay healthy?'. This question fitted with my research objectives of gaining information about young people's role in promoting their own health and that of their families as well as general conceptions of health and health practice but was also intended to be as open-ended as possible in line with the inductive

nature of photovoice. Young people took cameras home with them for a period of between four and six days to take pictures before I collected them in order to print the pictures.

Following the seminal work of Wang and Burris (1997), I wanted young people to be involved as far as possible in the three-stage process of participatory analysis: selecting; contextualizing; and codifying (ibid.: 380). Although expensive, printing hard copies of all images that young people took (including personal ones) enabled this interaction. To facilitate the selection of images, I asked young people to sit together round a table. I distributed printed pictures to individuals and asked them to label their own images with their name and session number. Particularly at the beginning, young people took many personal images of family, friends, teachers, their homes and self-portraits. I therefore asked them to remove images which they felt were not related to the homework question. Participants then selected three-five images which they wanted to share with the class. Photographs were clipped to a piece of string that was hung across the classroom and I asked young people to take it turns to stand in front of their images and answer a series of questions I put to them. Following this process of contextualising, I asked young people to work together to re-order the pictures thematically (codifying) before summarising their findings.

This session revealed a lot about conducting photovoice in this particular setting, especially in terms of eliciting information from participants. Although I initially tried to follow the SHOWeD mnemonic (What do you **See** here? What is really **H**appening? How does this relate to **O**ur lives? **W**hy does this problem or strength exist? What can we **D**o about it?) suggested in much of the literature (Shaffer 1973; Wang, Yi et al. 1998; Strack, Magill et al. 2004; Catalani and Minkler 2010), this did not prove successful (as discussed further below). Instead, over the coming weeks, I tried and refined a range of questions before deciding on three which young people most easily understood and seemed most relevant to the sessions. The most significant adaptation I made during these early sessions was to offer young people the option to write their thoughts about pictures down before verbally presenting them to the class. I gave young people a worksheet with the questions I had decided on as a frame of reference but also encouraged them to write whatever they wanted to about pictures. Young people overwhelmingly preferred this method to spontaneously presenting orally to the group

which I observed they found stressful and difficult at first, often becoming very shy, reserved and even monosyllabic. Giving young people time to think, reflect and record their thoughts before sharing their ideas may have lessened the spontaneity of the encounter. However, in this context, I discovered it was a much more suitable method for eliciting information. Again, this is discussed in more detail below.

Following this initial exercise, in subsequent weeks I asked the young people to explore the question, 'what does malaria mean to you?'. Again this question was directly related to my own objectives but was purposefully open in nature. Each week, we repeated much the same format as described above; images were printed, distributed and labelled; looked at collectively and sorted; described and contextualised by individuals; and analyzed and codified as a group. At first, I asked young people to only select and group and discuss their own pictures but, as weeks went on and this process was repeated, young people became more and more comfortable with the idea of thematic analysis and combined all their pictures together to sort and describe. On the whole, we hung pictures on the string and young people selected a group of images they wished to talk about including ones that were taken by other people. At the end of each session, we reviewed all the pictures again to see if the images could be re-grouped or re-ordered, summarized findings and identified possible gaps or areas of further exploration with the same question in mind: 'what does malaria mean to you?'. At the end of each session, pictures were kept in their groupings and laid out at the beginning of the next session for young people to add to or re-organise in light of new pictures. In this way, the photographs, as physical objects, were constantly referred to and used in all sessions. This iterative process continued until around the ninth or tenth week at which point all groups felt they had had enough time to take pictures and wanted to move onto the next stage – the planning and implementation of outputs.

In order to evaluate how young people felt about photovoice, I devised a very short (five question) written evaluation sheet which I gave young people to fill out in the tenth week.

### ***9.1.3 Phase 3: planning and implementing outputs***

A central component of photovoice when used as a method of PAR is the dissemination of group findings to communities and/or decision-makers (Wang 1999). From as early

as the consenting process, I informed young people that a major objective of this project from my perspective was for them to take action and potentially initiate change by sharing their findings with their peers and/or family members. However, I explained that the way they did this was their choice and would be worked out in the process in order to try and make this aspect of the study as participatory as possible. During phase two, we began honing in on what the main findings were and, by week nine or ten, depending on the group, all five groups felt they could now use their pictures to communicate with others.

In order to stimulate a discussion related to dissemination and outputs, I began by showing young people possible options of things they could do with their photographs before eliciting their ideas and opinions about what they wanted to do. I showed them pictures of photographic exhibitions as this is the most common form of action taken in photovoice projects (Catalani and Minkler 2010) but was conscious of the fact that they had never seen such a display before and were not familiar with the concept. I had received funding from the University of Durham to make a participatory film with young people using their pictures so I also showed them examples of similar films from other projects. In one school, Matyag Elementary School, the teachers suggested that they could hold a health awareness event once a month where photovoice participants could help teach other young people as well as their families about what they had learnt. We discussed the idea of using the pictures generated in photovoice to make checklists which the young people could use as a memory aid. This idea was also presented to the young people of Matyag Elementary School. When opening up the discussion to gain young people's ideas of other possible outputs, I found that universally, in all groups, they struggled to think of what they could do with their images or alternative means of disseminating health information. When I asked them 'how can you use these pictures to teach people what you have learnt?', the only responses I got were along the lines of 'we will just show them'. Therefore, I also presented young people with a range of other options including making posters or leaflets, holding events, writing songs, stories or dramas etc. As a group, the young people then decided which of these options they would like to do. The final five weeks of the project were dedicated to designing and making a range of outputs.



In both schools, young people decided to make a photographic display and participatory film and planned an event in the school with their parents to present their outputs. As discussed above, Matyag Elementary School also decided to make checklists (see Figure 9.2) to use at home and on health awareness days. In Taysay Elementary School, the students decided to use their pictures to make posters for their homes.

For the exhibition, all the photographs were laid out on a table in their groups and young people selected one or two of the images from each group that they thought best represented the messages that they wanted to teach people from that group. Together, we discussed what the messages were before young people individually wrote the final caption text for the display. I had the final images and text printed and laminated for the exhibition. I felt it was important that each child had a least one picture and wrote at least one caption for the display. Once exhibitions were completed, initially they were temporarily installed for display at the community events organised in each school. Following on from this event, both schools found permanent places to hang the exhibitions.

Similarly, in order to make checklists, young people worked together in their groups to select the images and messages they felt were most important. We decided to make two checklists: the first represented things people could do every day to stay healthy (reflecting the first photo-taking session); and the second focussed on things that people could do to prevent or treat malaria. Each of the three groups in this school produced two checklists: one that related to general health; and one that related to malaria. The specific content varied between groups but contained instructions of things to do every day like 'plant flowers to make the environment beautiful', 'exercise every day', 'have a blood smear test so you know if you have malaria' and 'slap mosquitoes off you if they land on you'. Again, I had final versions printed and laminated for each child to take home and display in their homes.

**Figure 9.2 Example of a checklist on ‘how to stay healthy’ produced by young people as an output from photovoice. Source: author.**



### English Translation

1. Eat vegetables to be healthy
2. Drink water so you are not thirsty
3. Wash the plates to be clean
4. Wash your hands before you eat
5. Take a bath daily to have a clean body
6. Hang your laundry to dry to be clean
7. Clean your surroundings so that they look good
8. A fire can be lit at night to cook and give light
9. Herbal medicines can be used to treat diseases in our bodies

For the groups who decided to make posters (see Figure 9.3), young people selected from their own pictures the ones that they wanted to incorporate into a poster. As with the other outputs, the form these posters took and their content varied between participants as they selected their own personal images and messages to depict on the posters.

This activity was initially quite difficult as most young people were not clear about what posters were and had never made one before. In the end, although every child made a poster, this process was much more facilitated than I had expected and less creatively ‘free’. I had to simplify this into the idea of selecting three-five images and appropriate message to form the basis of the poster.

**Figure 9.3 Photographs showing young people making posters as an output from photovoice. Source: author.**



For the participatory films, an independent film maker from the UK joined the group for three weeks in order to co-facilitate the production of a short film that incorporated some of the images and messages from photovoice. At this stage, I brought the individual groups from each school (three in Maytag Elementary School and two in Taysay Elementary School) together to form one large group in each school. Young people selected whether or not they wanted to direct, script-write, act in or shoot the films. In each group, images selected for the exhibition inspired young people to write a story which they then turned into a film. Again, this meant that young people in each group had control over the messages of each film and what they felt was important to communicate with their peers and family members. It also meant both films were quite different in terms of format and content. In Matyag Elementary School, the group of writers, inspired by an image of an older woman sleeping under a mosquito net, wrote a narrative story that followed a grandmother and her grandchildren after they became sick following a trip out to collect firewood. After visiting the traditional healer, who was unsuccessful in treating them, the family went to the health centre where they had a check-up and blood smear test and were diagnosed with malaria for which they were given allopathic treatment. The film ends with a series of health messages based on photovoice images including ‘we must spray our houses to remove mosquitoes carrying malaria’ and ‘every night when we go to sleep we must sleep under a mosquito net’. In Taysay Elementary School, young people took a different approach and wrote a narrative that was inspired by an image of a mosquito and centred on a battle between

two mosquitoes and a group of children being bitten by them. After defeating the mosquitoes, the children report what happened to their older relatives who give them advice on how to manage mosquitoes and prevent malaria in the future. The advice given includes things like, 'use Advance Aerosol spray to avoid mosquito bites' and, 'tame some animals like dogs, pigs and other animals so that they are the ones who get bitten by mosquitoes instead of you'. The first week was devoted to: establishing a script with the writers and directors based on the photovoice images, training the cameramen; and giving the actors time to practice. The second week was devoted to filming and the third week focussed on recording sound effects and audio as well as participatory editing. The final films are included in the enclosed DVD at the back of this thesis (Appendix 5).

## **9.2 Situating photovoice in context**

Having described the practical implementation of photovoice in the previous section, I now provide an analysis of how the specific context in which photovoice was conducted affected both the way the project practically unfolded but also the data gathered. These contextual factors include power and positionality, the co-facilitation process, the low-resource setting, reactions to and use of cameras and the process of conducting participatory analysis. In the next section, I discuss each of these issues and provide a detailed description of the adaptations and innovations that I introduced to the method in order to address some of the challenges I faced.

### ***9.2.1 Reflexivity, positionality and power***

Reflexivity in anthropological work is a long established concept (Clifford and Marcus 1986). Precisely because fieldwork is 'in its nature, a messy and complicated process' (Bourke, Butcher et al. 2009: 95), there is a requirement to stand back and assess not only processes but also the position of the self in relation others. Establishing a relationship with participants is an ongoing process throughout fieldwork and central to the formation of these relationships is the idea of positionality. I use the word positionality here to refer to structural factors (material, social, political differences) that placed me and my participants in certain categories in relation to each other but also to more physical preoccupations when doing research together (where we sat, what we wore, how we spoke etc). Together these factors affect and reflect how power is distributed between researcher and participants, how it is negotiated in time and

space, the kind of knowledge generated throughout the process and the way in which this knowledge was created.

Throughout fieldwork, I was conscious of how certain factors affected how I was perceived and received by participants. Being a relatively young, unmarried, female, travelling on my own brought with it a lot of interest and sometimes concern from people. Although people often remarked that I was very 'brave' to be travelling alone, they were puzzled and even alarmed by my lack of companion. My different socio-economic status, educational background, nationality and language put me in the general category of 'rich foreigner' and more specifically 'American' (despite being British) which brought with it negative connotations of colonialism and suppression. People were initially suspicious of my motives, suspecting me to be a 'treasure hunter' in search of gold bullion allegedly hidden by Japanese colonisers. Similarly, my interest in health and medicines caused some people to worry that my intention was to steal native medicinal plants and secrets for personal economic gain. Even though many of these concerns were assuaged relatively quickly, I was continually conscious of being an outsider to a large extent.

Positionality certainly affected the photovoice process and outcomes. Young people were not exposed to many outsiders and Palawan people in particular have a reputation for being friendly, but introverted. One teacher, who came to the school two years ago from another part of Palawan, told me that students initially ran away from him when he first arrived and did not look or speak to him for many weeks. This was not dissimilar to my initial encounter with young people in the field who were painfully shy and quiet in initial encounters. Like the experience of the teacher, they would: not look at me whilst talking; would speak very quietly, almost in a whisper; and were sometimes unresponsive to questions about their opinions or lives, answering that they did not know or with silence.

I became aware of this through initial months of ethnographic research so, when it came to photovoice, I tried to adapt my behaviour and physical appearance in order to try and 'blend' in as much as possible and make young people feel more comfortable. Working with a translator meant that I had to adapt my language to some extent anyway but when working with young people, I tried as far as possible to speak using terms they

would understand and incorporate as much locally relevant vocabulary as I could. Similarly, I dressed in clothes that, although still signalled me out as a foreigner, were largely bought locally.

In an effort to make young people feel more comfortable, I started each session with games in which I not only participated in but consciously tried to highlight my ability to make mistakes, get caught out or look silly. I ensured we all sat on an even level in a circle, trying to break with the convention of a teacher standing above seated rows of pupils at the front of the class, and told young people they could refer to me by my first name (although most continued to refer to me as Mam or Miss Dalia). When I asked young people questions, I tried to give them as much time as possible to answer allowing for long silences but moved on when I felt young people did not want to or could not provide an answer. Giving young people time was a very important aspect of sessions and also came about through the observation of my translator who felt that, although participants had a lot to say, they were too shy to verbalize it or felt constricted in some cases by the use of Tagalog. However, it was difficult to strike a balance between sensitivity and the time pressure of the sessions and the need to actually elicit data. The adaptations made in session to deal with this are discussed further in the section relating to data elicitation. What is important to note is the recognition that my position as an adult and an outsider created a situation in which young people were, at first, not wholly comfortable with sharing information with me. At times, I felt they did so out of a sense of obedience instilled in them through school where teachers commanded a lot of respect. Often, if young people were quiet in sessions, teachers would reprimand them. Throughout the process, I really wasn't sure how to interpret young people's behaviour towards me. Was it a reaction to me personally or was it a reaction to being asked to participate in activities that were different to what they were used to? I am still not sure what the answer to this question is. However, my observation is that over time as our relationship with each other developed, young people certainly did transform in terms of their willingness and ability to participate.

The changing nature of participation was both reflected in and facilitated by a number of material objects that came to symbolize the shifting nature of our relationships: the lessening gulf between researcher and participant; adult and child; and outsider and

insider. At first, young people were very reluctant to accept food from me and were equally shy about eating it in front of me. Concerned that I had made them feel uncomfortable, I asked my translator and the teachers whether this was normal or simply a reaction to me. They explained that there were a variety of possible explanations. For the majority of young people, lunch was the only meal they ate during the day and this usually consisted of a small amount of plain rice or a couple of boiled bananas or cassava. Some students did not eat at all during the school day despite walking long distances to get there and so, by in large, were extremely hungry. Embarrassed by this, they were hesitant to admit that they wanted the food I offered to them. Hence, their initial reluctance and seeming ambivalence to it. Furthermore, as described in chapter 2, sharing and giving are important concepts in Palawan culture which is characterised by positive reciprocity (Macdonald 2007). Consequently, participants were initially hesitant about their inability to reciprocate my offering of food (and in particular rice). However, as time went on, young people came to sessions bearing fruits and vegetables from their gardens for me to try and take home as well as small gifts of jewellery or baskets that they had made or exchanged. As the group bonded, both with each other and myself, participants became much more comfortable accepting and reciprocating food and, by the end, eagerly lined up to help themselves and we ate together.

Similarly, cameras as objects moved through communities acquiring associations, meanings and significance and drawing people together in webs of social relatedness. At first, people associated me with shiny expensive equipment like my own point-and-shoot camera that I got out in almost every interview to take pictures. Older participants were particularly excited and asked me questions about its provenance and cost as well as to take and print pictures of them. Once I brought fifty cameras with me for the photovoice project, news spread fast amongst my neighbours and members of the community and before long, a range of people asked me if they could borrow one for various activities. As a result, cameras, rather than simply marking me out as different, came to bridge gaps between me and the community as they accompanied people to weddings, family gatherings, funerals, church services, parades and school events. As I built up relationships with people, they asked me if I could gift them a camera after I left. This included my translators, driver, host family, teachers, parents, health workers

and friends. As a result, even after I left the field, the cameras that I give as gifts remain as symbols of the strong friendships that I made. The pictures that are now taken with them continue to maintain these friendships across time as space as they are shared with me through email and social media. Students, too, were extremely excited by the cameras as, although many of them had seen one before and had their pictures taken (mainly by teachers), they had never handled them or taken pictures themselves. Cameras that were associated with me soon became theirs to use, play with and care for. Once the young people received these cameras for themselves, the majority kept them openly hanging from colourful straps round their necks, taking them with them to school, home and around their communities. Cameras accompanied young people as they ate, slept, studied or played. They invited comments and questions from their peers and family members as well as invitations to take people's pictures or show them what they had been documenting.

Photographs, as material objects played a similar role in drawing me into communities. Almost everyone I met asked me to take pictures of them. I printed these and offered them as gifts to participants and friends. Pictures that I took appeared on people's walls, were hung in classrooms or were put in family albums and almost always included pictures of myself which people wanted as a 'remembrance'. Participants' printed pictures were received with a lot of pride and excitement and thus photographs helped bond people together as they were exchanged between participants and members of the community as gifts.

### ***9.2.2 Co-facilitators***

As well as my own positionality in relation to participants, that of the other facilitators also affected the project. The nature of photovoice means it would have been impossible for me to conduct sessions alone, mainly because of the language barrier. My translator, a middle-aged evangelical pastor from another indigenous group in Palawan, was present in all interactions I had with young people and my relationships with them were entirely mediated through him. He was extremely enthusiastic about the methodology and was keen to use it in other aspects of his pastoral work. Young people responded very positively towards him, partly because he was well known to most of them but also due to the enthusiasm and humour he injected into sessions. He became instrumental to the success of the whole process. As well as directly translating for me,



he also co-facilitated sessions and played an influential role in helping young people one-on-one or in small groups.

In order to try and foster a sense of ownership in schools, I provided a day-long training course for my translator and teachers which comprehensively set out the theoretical and practical basis of photovoice as well as providing time for teachers to experience using the method themselves. I emphasised my desire for teachers to help co-facilitate sessions and we discussed the long-term sustainability of the project. Although they were extremely positive and excited by this by the end of this training, and as far as I could tell had grasped the aims and methodology of photovoice, when it came to the actual sessions teachers took a rather back-seat role. In part, this was due to practical issues. Teachers said that they were often tired and in need of a break to eat their lunch and rest during lunch time. The teachers-in-charge at each school were absent the majority of the time I was there, having to attend meetings and seminars. Other staff also had *ad hoc* seminars or meetings to attend to or their own work that they needed to do in break times. This meant that teachers were not always able or willing to be present in sessions. In addition, teachers clearly felt that they were not adequately familiar with the technique, despite attending the training course, to actually co-facilitate the project themselves and continually remarked that I was the 'expert', not them if I tried to encourage them to take a more active role in planning and executing sessions. This obviously has implications in terms of the participatory nature of the project as throughout, and perhaps not surprisingly, I felt that I was leading the project in terms of not only guiding the participants but also the adult facilitators. Teachers looked to me for instruction and guidance and would always ask what exactly *I* wanted them to do, undermining the collaborative nature of the nature of the project that I had hoped to establish.

When teachers were present in sessions, they, like my translator, were instrumental in helping young people to carry out tasks or write down or express what they wanted to say: something I felt restricted in doing alone due to the language barrier. They also provided a practical link in the school to remind young people of their 'homework' exercises, and to bring in their cameras and collect cameras on my behalf. Despite the positive contribution of staff, I was aware that teachers were not able to reconfigure relationships that they had with young people, preserving rather authoritarian roles

instead of more facilitative ones which would have been better suited to this participatory process. They would act as disciplinarians in sessions and in their interactions with young people would often stand over them, watching them and pointing out grammatical or spelling errors in their written work or reprimanding them for not participating, speaking up or talking etc. as they would do in a lesson. While this was necessary in some ways to help keep behaviour under control and keep sessions going, I felt it inhibited young people's ability to express themselves fully and freely. Similarly, teachers sometimes reacted negatively to what students expressed if it differed from their own knowledge, what teachers had tried to teach them in school (for example regarding the body or medicines) or what they thought I wanted to hear. Even when teachers did not express this directly through words, they did so through body language such as laughing or sighing which gave a strong signal to young people that they were saying something 'incorrect' or 'silly'.

While the success of photovoice would not have been possible without the support and involvement of the teachers, thinking critically about the process, involving them as true co-facilitators was probably too ambitious and in the end, was one of the least successful aspects of the project. Partly, this was due to the practical demands of photovoice. I could have invested more time on facilitation in initial training and included teachers more in the planning of sessions on a weekly basis. Additionally, teachers did not have the time and sometimes willingness to participate more than they did which I had not anticipated. More than this, I question whether teachers are the best people to facilitate a participatory process such as photovoice due to the pre-existing relationships they have with students which are not easily reconfigured, especially in the time we had for this particular project. This has implications for the potential scalability and sustainability of the photovoice in this context. Although teachers and students were left with the equipment to carry out more projects in the future, it is questionable whether or not teachers will feel they have the time, resources or expertise to do so<sup>9</sup>.

An important note about the facilitation process is that this was the first time this group of people had worked together to conduct a project of this nature and, as facilitators, we

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<sup>9</sup> By late 2014, the only update I had received was that one school had not used their cameras again as they did not have the resources to buy replacement batteries for them.

all reflected throughout the process how much, we, as much as the young people, were learning as time went on. Because my translator and I were conducting five of the same sessions a week with different groups, we often found ourselves discussing how challenging the first session tended to be compared to the last one, by which time we had refined a lot of the processes, activities and the way we spoke or explained things. Although these were seemingly subtle changes and all sessions/activities were essentially the same between groups, we felt that this affected the way in which each of the groups understood and engaged in the process and therefore in the results that were produced. While this way of doing things may have advantaged the later groups, conducting five sessions a week also meant that both my translator and I were somewhat tired by the end of the week which may have negatively affected the latter sessions. While constant evaluation by the co-facilitation team helped us to be aware of these issues, it may have been better to pilot the whole 15-week process first with one group before starting the process proper in order to help mitigate some of these issues.

### ***9.2.3 Working in a low-resource setting***

As previously mentioned, sessions were conducted in schools during the lunch break to cause as little disruption to lessons as possible. Once morning lessons were over I would use one classroom for our sessions, setting up the space whilst the young people finished eating their lunch. I usually arranged the chairs and tables in the room in a circle and the students assisted in sweeping the floor and moving furniture. The issue of space did cause some minor problems as, if sessions overran (which I tried my hardest to avoid), this affected subsequent lessons.

Despite trying to create a private and quiet space, the project unsurprisingly attracted a lot of attention from other children who continually crowded around classrooms, peering in through the windows or sneaking in through partition walls to sit and watch. When parent meetings were held at the school, parents, would also observe sessions through the windows. Continuous noise from playing children outside and very heavy rain provided a constant backdrop to sessions. Together these factors partially undermined the creation of private, quiet spaces for us to conduct our sessions. However, as described in chapter 3 in reference to interviews, the concept of individual privacy was somewhat difficult to enforce and not culturally appropriate in many

encounters. As such, participants didn't seem at all phased by non-participants who were a removed but constant audience to our sessions.

So as not to incur extra costs to either the young people or the school, I provided all the stationery used in sessions including paper, pencils, folders, art materials etc. As the schools had no electricity, I also purchased a portable generator and supplied gasoline, a laptop, projector and screen when this was necessary. On the whole, I printed pictures for sessions and all printing was done at a local print shop. Once young people had decided on the outputs they wanted to produce, I also supplied all materials for these activities as well as cameras, cards, cases, batteries, food and transport. It is therefore important to take account of costs incurred for running photovoice sessions, particularly in low-resource settings. Again, this has implications for both the scalability and sustainability of photovoice in such settings.

#### ***9.2.4 Reactions to and use of cameras***

Following seminal publications on photovoice, much of the literature recommends including training on the ethics and potential ethical implications of conducting such a project (Wang and Burris 1997; Strack, Magill et al. 2004; Catalani and Minkler 2010; Findholt, Michael et al. 2011). Accordingly, as described above, I incorporated this into the training I provided for both co-facilitators and participants. Discussions about the potential ethical implications of taking photographs were also an integral part of discussions with communities throughout the consenting process. Many photovoice accounts present cameras as an a-cultural technology that produces similar results in any socio-cultural setting (Prins 2010). However, it is important to document how these objects interact with cultural contexts.

In general, all people that I spoke to about the project were extremely happy and excited about the prospect of cameras. During scoping visits and consenting, no-one expressed any of the anticipated negative implications of young people possessing or using cameras that have been reported in other studies such as potential changes to power dynamics or cultural barriers such as the potential for encouraging embarrassment, shame or even witchcraft (Prins 2010). The only sentiment expressed was that participants wanted to be sure about repercussions if any of the equipment

was damaged or lost. People were keen to clarify whether or not they would be obliged to pay for the damage of such an expensive item of equipment.

Young people in particular were very excited by the prospect of taking pictures and, once they received a camera, were visibly eager to open up the cases and begin using them. In the evaluation, young people did say that they were initially worried about damaging or losing cameras and the consequences if they did, highlighting the need to be aware of young people's worries and anxieties. On the whole, despite never having handled cameras before, young people grasped how to use them very quickly as well as concepts that were new to them like framing, composition, and vantage point. This was mainly through the activities that we conducted in the first three weeks. Throughout the project, only one child reported having practical problems as she accidentally deleted all of her pictures from one week. Apart from a couple of small technical problems with memory card errors, young people did not report any major technical issues and successfully changed batteries and cared very well for their cameras. No equipment was lost or damaged in the process.

As I describe in the next chapter, the majority of participants reported that learning a new skill was the aspect of the project that they liked the most. Young people did not report any problems regarding reactions to their possession or use of cameras in their communities. They reported that the people they asked to take pictures of were obliging and happy and that no one had any negative reactions. Only one child reported that a relative asked her where she got the camera from and if they could borrow it. We had dealt with this issue in the session on ethics and, the child felt that she was adequately able to deal with the situation by explaining that I had entrusted the camera to them for sole use in the project. Similarly, discussions with community members who had their pictures taken, revealed that, far from being a negative experience, people enjoyed having their pictures taken and reacted with excitement and enthusiasm when they saw themselves appear in printed images, especially those included in final outputs. Many people remarked how they liked having their pictures taken because it meant they were now 'famous'.

When it came to taking pictures, some young people said that they were initially unsure about what to take pictures of but, as time went on, they felt more confident about

knowing what to document. Some participants could not access all the things they wanted to take pictures of (e.g. health clinics or people suffering from malaria) for a variety of reasons but did, in some cases, find creative ways to overcome this (e.g. photographing images in books or acting out scenarios). Participants reported, and I observed, that they mostly took pictures in small groups, usually with close friends or family members, rather than on their own. This did affect the results to some extent as young people tended to take pictures of similar things to each other each week. This was partly due to the discussion we had in each session where we identified things that were missing. However, I believe it was also due to the fact young people were taking pictures together.

Despite the largely positive experiences that participants had with cameras, I did observe one unanticipated ethical issue that arose in relation to the subject of images. In order to take pictures of mosquitoes, some young people captured mosquitoes biting themselves or other people. While young people did not report actively trying to encourage mosquito bites, the act of trying to capture this may have inadvertently led them, or those being bitten, to engage in risky behaviour (i.e. by not slapping mosquitoes off). When this problem arose, we discussed it and agreed that participants did not need to take pictures of mosquitoes biting people and discussed other 'creative' ways that they could use to capture this idea.

### ***9.2.5 Participatory analysis***

As described above, photovoice involves a three stage process of participatory analysis: selecting, contextualizing and codifying (Wang and Burris 1997). Below, I document some of the methodological and epistemological challenges relating to this.

#### ***9.2.5.1 Selecting images: a selected view***

In line with the participatory nature of the method, participants select images for discussion in order to 'define the course of discussion' (Wang, Yi et al. 1998: 80). As described above, printing all images for participants meant that they could use the material objects in a tangible way to select the images that they wanted to discuss. I started each session by asking young people to label and sort their own images before moving on to contextualising and codifying them. This allowed participants to select which images they thought were most relevant to the sessions or ones that they simply

liked. As time went on, participants sorted, selected and described not only their own images but also those taken by others. Two important observations came out of this process.

First, in terms of what young people felt was relevant, there are some questions regarding the 'authenticity' of data generated in this process. After the first couple of weeks, young people pooled their images to discuss, consider and report on. This meant many of the narratives and meanings expressed orally or written down were created by people who did not actually take the photographs. Although young people were encouraged to discuss the context and significance of the images that they were describing with the people who did take them, this did not happen with all images due to the volume of pictures and the limitation of time in sessions. The issue of authenticity is compounded when working in a context such as this where young people may be reluctant to contest others due to power differentials (like relative age or familial relatedness) as well as a desire to arrive at the 'right' answer. Consequently, there is a risk that the selection process results in some individual knowledge or voices getting lost as the group tries to find consensus. Furthermore, as described below, young people adopted a number of narrative devices such as imagination, memory and story-telling when describing their images and in activities such as the making of films and posters. Using images in this way, as opposed to other less 'creative' methods for collecting qualitative data, perhaps compounds the problem of losing voices in the process as 'real' life experiences become expressed or woven together with other narrative forms. However, it is also important to acknowledge the epistemological implications of this view point as it is couched in a post-positivist framework, where objectivity is the goal in an attempt to find the "truth" (Fournier, Bridge et al. 2014). This loses sight of the fact that all knowledge is in fact situated and co-constructed. Photovoice, as a research method, facilitates the co-construction of knowledge. As such, as researchers, we should acknowledge that what is produced in the process is not a 'reflection' but a new *version* of reality.

Second, in terms of young people selecting images they 'liked', it is important to acknowledge how culturally-mediated qualities that inform these choices like 'aesthetics' and 'beauty' are. For example, during training, I described ideas of composition in photography which are largely rooted in contemporary Euro-American

philosophical traditions. This included the practice of 'breaking frame' where the subject of images is only partially captured. While this idea has come to be regarded as artistically desirable in Euro-American aesthetics, here, the participants stated that they did not like this style and preferred images in which the whole subject was visible in the frame as it was 'clearer' and 'easier to see' what was on show. Similarly, young people were not put off by features like blurring due to lack of focus. In fact, one image that was chosen for the final exhibition by one group was a very out-of-focus mosquito. Although there were other pictures that they could have chosen showing the same subject, they felt that this image best illustrated a mosquito biting a person and did not mention the fact it was blurred in their negotiations with each other. In this way, what young people 'liked' differed to what I perhaps expected.

#### ***9.2.5.2 Contextualising***

After selecting images, the next stage of the process is for participants to provide contextual information about their images as photographs alone, considered outside the context of participants' own voices and stories, would contradict the essence of photovoice' (Wang, Yi et al. 1998: 80). Participants contextualise their images by providing narratives about photographs in facilitated group discussions. Much of the literature on photovoice suggests doing this orally using a root-cause form of questioning called the SHOWeD technique in order to elicit data from participants about their images. Using the SHOWeD mnemonic, facilitators are suggested to ask, (a) What do you **See** here? (b) What's really **H**appening here? (c) How does this relate to **O**ur lives? (d) **W**hy does this problem, concern, or strength exist? and (e) what can we **D**o about it? Each question is designed to enable participants to not only explore deeper issues raised by the image but also discuss causes and potential solutions (Shaffer 1973; Wang, Yi et al. 1998; Strack, Magill et al. 2004; Catalani and Minkler 2010). Although I did initially use this form of questioning in the first session with young people, it did not prove entirely successful.

For example, question (a) relied on participants giving primacy to visual information provided by images in order to describe what they saw. As described below, visual literacy was not an automatic skill in this setting and took time to develop. The next questions, about what is 'really happening', 'why' and how this 'relates to life', were problematic to translate and difficult for young people to answer as they took them very



literally. Many pictures did not necessarily document 'problems' or 'strengths'. Young people mostly answered that 'nothing is happening' and 'I took this picture because you told us to take pictures'. As described above, I modified the form of eliciting data by asking three different questions:

1. What do you see in this picture?
2. How does this relate to malaria?
3. What do you want to show/teach people with this picture?

I modified the process of contextualising images further by giving young people the option to write their thoughts about pictures down before verbally presenting them to the class. In early sessions, the other co-facilitators and I noted that most young people stood quietly with their head bowed after being asked a question, muttering to themselves and thinking. They looked uncomfortable standing in front of people and spoke with their hands in front of their mouths or with their heads and bodies turned away. Allowing young people to spend time thinking and formulating what they wanted to say in writing made the situation less stressful and difficult for them and allowed me to elicit fuller and more detailed answers. It also gave the young people more time and space to work in groups and consult each other or work together to share and discuss images. This placed more emphasis on the *co-creation* of knowledge, rather than on individual performance which, in this context, was difficult (and perhaps not desirable) for young people. However, it is important to note that even these modifications did not alleviate all problems as some young people also found writing difficult, especially in Tagalog. While my translator tried hard to encourage people to speak or write in their native Palawano, they were reluctant to do so due to the shame that they associated with identifying as ethnically Palawan (as described in chapter 3). Additionally, my translator argued that Palawano is a relatively restrictive language compared to Tagalog and English. These issues highlight how photovoice, although a creative visual methodology, is still very dependent on verbal literacy in terms of contextualising images as the emphasis is on asking questions and verbalising knowledge.

As mentioned above, one of the aims of the initial sessions was to for me to establish the level of 'visual literacy' of participants. In terms of exposure to pictures, schools were decorated with many different kinds of pictures from illustrations to factual images in text books. When I visited young people's homes, many had pictures cut from fashion magazines stuck on walls and a few had photographs. However, in sessions, the majority of young people were not able to think of an image from memory and struggled to think of the different functions pictures had. In some groups, young people suggested pictures could be used to provide information and for 'remembrance'. One child said that she had used pictures to document her cultural practices to keep a 'record' in relation to a community project her family was involved in. Those that did describe pictures from memory overwhelmingly described family photos that they had up in their houses. Overall, the idea that images could be used to teach people was not well established at the beginning of the project which meant participants were slightly perplexed by the methodology and the potential of what they could do with pictures. As described above, when it came to discussing outputs, young people did not offer any ideas of things they could do or make with their images.

In terms of 'reading' images, initially young people were very unsure of how to describe the content of pictures. In particular, they were not familiar with the concept of depth of field (foreground and background were simplified into describing what was at the front and back of the image) or providing context to what is 'seen' in the image. When I asked young people to describe images for the first time, their descriptions of content were very succinct, even with supplementary questions from me:



'Participant: There are some fish (*long silence*). The fish are orange.

Me: Can you see anything else in the picture?

Participant: No, just the fish'

Similarly, when young people were describing their own pictures in early sessions, they were equally concise, often pointing out only the main subject of the picture and providing little contextual information in which to situate the image:

'Me: What can you see?

Participant: This is a broom [long silence]

Me: Can you only see a broom?

Participant: Yes

Me: [pointing at the broom] So this is the broom? Is there anything else in the rest of the picture? [pointing to other areas of the picture]

Participant: [long silence] She is using the dustpan

Me: Can you describe everything in the picture that you can see

Participant: [long silence] There are young people playing

Me: Is there anything else you can see?

Participant: No'



Images as visual cues select for the sensory experience of vision above all others. When looking at pictures, young people were reluctant to describe things that they felt others could already see and were therefore 'obvious'. However, as time went on, participants developed an understanding of the objective to describe details of pictures in order to effectively communicate with others regarding the intention and meaning of their images. As the project progressed and young people took more pictures, their descriptions moved beyond simply stating what they could 'see' towards describing the conditions behind the images' contents as well as their wider meaning and significance:



‘You can see one open cooking pot and you can see rice inside and the serving spoon is not yet removed. You can see in the surroundings there is a lot of trash. You can see plastic, trash, dirty cooking materials. If the whole night will pass by with the same situation of the cooking pot, I’m sure mosquitoes will penetrate there and they will live there . . . inside the cooking pot because the rice will rot and it will become soggy and then this will be the place where mosquitoes lay their eggs’



‘In my pictures are two dragon flies. I took these pictures beside my house. I took these pictures to explain to you about the dragon flies because they can help us catching mosquitoes so their numbers will decrease’

In this way, the visual literacy of participants developed throughout the photovoice process but it did take time and cannot be assumed to be a skill which is necessarily universal in all contexts.

As is consistent with the literature on visual research, the visual stimulus of an image can prompt participants to construct verbal narratives and explanations around images that go beyond what they can literally see (Collier 1957; Collier and Collier 1986; Harper 2002). While this did happen to some extent I found that this, too, developed over time. For example, when asked to describe pictures that they had never seen before, some young people did employ imagination in their narratives. The example below is a description of an image of a young boy running in the rain with little else captured in the picture:

‘Participant: This person is stealing something that does not belong to him. Maybe he has snatched [some] things from the grocery store.

Me: How do you know that from looking at the picture?

Participant: Because he looks like he doesn’t have anything to eat’

*Joliver, male participant*

Similarly, young people employed imagination in order to contextualise pictures that contained content that they were not familiar with (i.e. when describing other people’s pictures) or images of fictional scenarios captured from books or posters:



‘Somebody is sleeping under the net and he was bitten by a mosquito. Somebody got malaria in the house because he was bitten by the mosquito. He is not drinking medicine like taking Paracetamol so that he can be healed. I can teach to the people that the person did not drink medicine for malaria’

As well as imagination, memory was also employed when young people described their images. As well as help them to recount the context of images, memory also affected the way they 'saw' in images. One notable example came from Mohammad, a 13 year old boy, who accidentally turned on the black and white function on his camera:



'Me: What can you see?

Participant: This is *ampalaya* [pointing]. It is good in order for you to get fat. There is grass and many colours in this picture [pointing]

Me: Can see many colours in the picture?

Participant: Yes like white, brown and green [other children look confused and laugh]'

While the perception of images incorporates multisensory experiences, it also incorporates another kind of experience – that of emotion. Photovoice is an effective method for allowing participants to express emotion as images are a powerful tool for eliciting emotional responses in people. The following excerpts are taken from young people's descriptions of different images and reveal how emotion is woven into their narratives, contributing to the constructions of meanings:

'There are five big stones and a tree. The colour of the stones are white and black. The grass is green. When I look at this picture, I feel lonely when I look at this because there are no other people there'

*Gina, female participant*

‘In my picture there is a motorbike. There are 8 motors doing the motocross. I see water and a swimming pool. I feel fearful because to fly the motorcycle is very dangerous’

*Jonel, male participant*

‘There is one big house and the background is yellow, green, white and blue. At the back of the house there is a lot of grass and weeds. I am happy when I look at that picture because there are a lot of colours’

*Jomer, male participant*

‘There is a big house. The heavens [behind it] are the colour blue. There is a big house where nobody lives, not even one person . . . The leaves are the colour yellow. I feel lonely because nobody lives there’

*Nornita, female participant*

### **9.2.5.3 Codifying: images as a point of departure**

The final component in the participatory analysis process is codifying whereby participants and facilitators analyse images and narratives together to identify issues, themes and theories. In particular, focus is put on identifying issues because ‘photovoice is well suited to action-oriented analysis that creates practical guidelines’ (Wang 1999: 188) for action.

The strength of photovoice is that images act as both a point of arrival for discussion but also one of departure, allowing participants to move beyond literal descriptions of lived experience to explore issues located outside of the image. Here, I concentrate on the methodological issues associated with this process of collaborative meaning-making. In practical terms, I asked participants to codify images by grouping them together at the end of every session, following the contextualising process (See Figure 9.4).



**Figure 9.4 Photographs showing young people working together to group images.**

**Source: author.**



The way in which young people grouped images changed over time and suggests that they developed analytical skills throughout the project. For example, in the first few sessions where young people used their own printed images, they initially grouped images according to literal content as opposed to theme. For example, a large percentage of images showed different kinds of herbal medicine which young people grouped into similar varieties (e.g. *sambong* or *tawa-tawa*). As the weeks went by, young people began to thematically group these images together into a combined category that represented ‘medicines for malaria’. In later sessions, young people made connections between different kinds of content and made associations between them such as cause and effect. For example, one group put these two images together in order to present to the class:



‘In this picture we can see the bed, the mosquito net, the pillow, the blanket and my older sister lying down on it with a sickness . . . She



got sick because of dirty surroundings because the mosquito carrying malaria is living there [pointing at second picture]. We can teach to the people to clean their surroundings because the garbage that is scattered is where the mosquitoes with malaria are living'

The strength of having printed out all the images was that photographs could be kept in their thematic groups at the end of each week and then reviewed and re-ordered in subsequent sessions with the addition of new images and knowledge. This meant that the process was iterative and as collaborative as possible. For example, one group put many images from multiple sessions together that displayed different content in order to demonstrate the theme of 'dirty places where mosquitoes live':



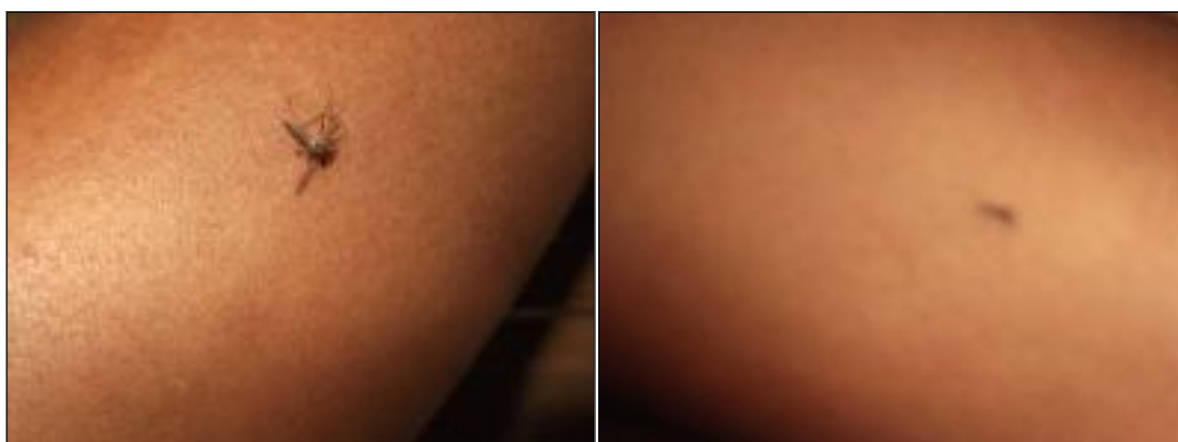
'In these pictures we can see the following: the scattered garbage in the surroundings of the house, plastics, sticks, star fruit, papers, leaves, grasses and cellophane. These are things that the mosquitoes are living in as well as in the dirty water. There are also the places where

mosquitoes are laying their eggs . . . We must clean the surroundings and we must burn the garbage also and put the garbage in the proper place and tie the pig like this [pointing] near the house so the mosquitoes will bite them instead of humans [laughing]. Clean the water to avoid the place for mosquitoes to live’

As well as allowing participants to develop themes, images also prompted discussion through which solutions to issues could be sought. Again, this was not automatic and developed over time through the process. Largely, this was facilitated by the question I asked participants about what they could show or teach people using their images. For example, in the early sessions, some participants did not link their images with the messages that they wanted to convey to people and were unsure of the concept that images could be used to teach people specific messages. In the example below, the student’s message about medicines for malaria is not directly linked to her images of mosquitoes:

‘In this picture we can see the mosquitoes carrying the malaria disease. There are plenty of leaves. The colours are green and brown. I took it in the back of our house. The mosquitoes who are carrying malaria are laying their eggs are in the garbage and in the forest. I can teach people that *katakatka* is a medicine for malaria’

This changed over time as young people became ‘expert’ at conveying messages that directly related to their pictures:



‘On Ronel’s arm you can see a mosquito biting and also one on Mailyn’s feet where the mosquito taking its rest. This is the mother

mosquito and the colour is white, black, brown and orange. If you are bitten by a mosquito you can have malaria . . . Avoid having mosquito bites so we don't get sick. We must spray our house and we must burn fire every day after sunset in our surroundings to take away mosquitoes. Use mosquito nets to avoid malaria'



'In this picture we can see a man doing spraying for the house to kill mosquitoes . . . The mosquitoes are the ones that carry malaria . . . What can I say to the people? They must spray and allow the spray man to spray their house to avoid malaria and if there is somebody who is identified as a spray man they need to spray their house. Do not refuse and say that you don't like to have the spray in your house because it is smelly. Let us not say to this spray man that we are not allowing them to spray our house because if we spray our house we will not suffer malaria and I will tell to the young people like me – they need to spray their house and I will tell their mothers also'

### 9.3 Conclusion

In this chapter, I have documented some of the practical and processual features of how young people and I *did* photovoice in order to ground the wider discussion about the outcomes of *doing* photovoice *within* practice. As with all methods, it is important to document how exactly photovoice was done *in context* in order to take account of the *situational* nature of the method and, by implication, both the lived experience of practice that was *depicted* and *altered* through photovoice as well as the anthropological knowledge generated about it. This is especially important as objects like photographs are at the heart of this research process and so central to meaning-making. Photographs confer many advantages in the research process and can be a rich source of data about

lived experience. As such, photovoice presents a useful means of carrying out interpretive phenomenological research (Plunkett, Leipert et al. 2012) as it allows participants and researchers to access the lived experience of practice in a way that is meaningful to participants rather than that which is most relevant to researchers. However, photographs, like all other objects, move through time and space, and as they do so, their meanings and significance change as they acquire social lives (Appadurai 1986). In the photovoice process, photographs are created that *depict* one version of reality captured because of the intentionality of the photographer at one moment in time. However, they then move throughout the research setting between the photographer, audience, participants and researchers and wider community as they acquire various narratives, meanings and uses. As such, photovoice does not so much 'uncover' one, underlying reality but *depicts* different, *situated* versions of it.

## Chapter 10: What pictures *did*: photovoice, action and change

Here, photovoice was used as a participatory action research method and, as such, phase three of the project was focussed on taking *action*. It is this aspect of the method that I evaluate in this chapter. I describe what photographs as material objects and the process of making and sharing them *did* and consider to what extent photovoice fulfilled its aim of ‘catalysing personal and community change’ (Wang, Yi et al. 1998). Due to the versatility of photographs, they enabled young people to create four major kinds of output that penetrated their own and their community member’s lives: exhibitions; participatory films; oral presentations; and pictorial checklists and posters. In this context, photographs also brought about a number of apparent changes amongst both the participants who created them and the people with whom they were shared. In particular, they: enabled young people to learn new things; make friends and be together; feel less shy and more able to teach others what they had learnt; and help alter their own and their families’ malaria-related health practices. Overall, photovoice seemed to change young people’s role in promoting health *in relation* to others. Photographs then, are significant, not just because of what they *mean* but also because of what they *do*. In this sense, photovoice *did*, in this context at least, appear to catalyse change. This chapter leads on to a discussion, in the next chapter, where I provide an explanation for *how* photovoice potentially brought about such change.

### 10.1 Photovoice outcomes

Once photographs, as material objects, were produced, their flexibility meant they could be used to create a range of outputs. Significantly, the form and content of the outputs varied between groups and even on an individual level. Accordingly, what photographs *did* as a result in terms of outcomes varied on a group and even individual level.

As well as allowing young people to make a number of outputs and take action, photographs and the process of making and sharing them also seemed to lead to a number of changes that participants considered to be positive. In order to assess these outcomes, I gave students a very short questionnaire to complete in the 10<sup>th</sup> week of photovoice which asked them questions related to what they had learnt, enjoyed and not enjoyed about the project. I conducted more in-depth follow-up qualitative

interviews and observations with participants in the four weeks immediately following photovoice. In order to assess longer-term change, I conducted follow-up questionnaires with all participants and their adult caregivers three-five months after the photovoice sessions ended. Young people reported a number of changes that will now be discussed in turn.

### ***10.1.1 Learning new skills***

One of the things that came out very strongly in evaluation interviews and observations was the enjoyment and happiness that young people expressed in learning new skills as a result of the photovoice project. Some of these skills were directly related to photography but others related to abilities like public speaking, reading, writing and drawing. This is demonstrated by the following quotations:

‘I am happy because Miss Dalia has taught us how to handle cameras and I have learnt together with my friends to take pictures about malaria because before I am scared because I might drop the camera but when I have known Miss Dalia I am no longer nervous – I am now very happy’

*Adralyn, female participant*

‘Yes I have learnt many things like how to make a drawing. I drew a house for the poster. [I also learnt] to read more. I read about mosquitoes’

*Jobert, male participant*

‘What I have learnt is how to use a digital camera and I have learnt now how to write’

*Anonymous (from written evaluation forms)*

‘Next time another photo project comes we will not be shy anymore, we will be bold. Because now we have been trained how to explain and to express our feelings in front of people’

*April, female participant*

‘I learnt standing in front of people and teaching them new things. I liked that’

*Sabturin, male participant*

Young people expressed a lot of pride in the fact that they had learnt new skills, so too did their teachers and parents who were very impressed with what they achieved. For example, when making posters, teachers expressed their surprise that students were able to produce them and were particularly impressed by the creativity of students regarding their ability to draw and decorate them.

In addition, young people felt that they had learnt how to conduct a photovoice project for themselves and were excited by the prospect that I was leaving most of the equipment with them to use in any future projects. This was a real change from when I first met participants as they struggled to understand what exactly this project would entail and its implications. However, by the time they had taken part, many of the students had ideas about the kinds of future projects that they would like to undertake utilising their new skills:

‘[I would do a project about] health - about eating nutritious foods to be healthy. That is a problem here. Because the majority of the people here are poor and it’s hard for them to look for food. We could teach people which are the foods that make your body strong’

*Relan, male participant*

‘[I would do a project about] disabled people so that we could know what is wrong with them. There is one girl like that over there. I know her mother. The girl is getting crazy. We need to treat her and take her to the hospital’



*Jeverlyn, female participant*

‘I would teach people about trees - how the fruit trees bear fruits, how to plant them. Because it’s a good way to show people’

*Jonathan, male participant*

‘I want to do [a project] again about livelihood so that we will show people many things about how to live here’

*Anonymous (from written evaluation forms)*

While it is certainly positive that the vast majority of young people felt they had learnt new skills as a result of this project, there is a risk that they will have limited avenues for using these skills again in the future. Although I did leave equipment (and skills) with teacher, they did not feel completely confident that they could carry out similar projects. They attributed this to a lack of their own skills, time and resources (as described in the previous chapter). All of the teachers felt they would certainly use the cameras in some way in school projects but, to date (late 2014), none of the teachers have reported conducting full photovoice projects. I return to these issues again in chapter 12 where I discuss suggestions for future research and the viability of using photovoice at scale.

### ***10.1.2 Making friends and being together***

Although young people already knew each other from attending the same school, they were brought together in new configurations for this project. The elements of being selected, doing things with existing friends and making new friends (including me and my translator) were expressed as positive outcomes by many participants:

‘My life is very happy because I was chosen together with my friends for this’

*Anonymous (from written evaluation forms)*



‘Yes of course [I have enjoyed this project] . . . I have also made a lot of friends’

*Norlyn, female participant*

‘[I enjoyed] being a companion of Mam Dalia and Pastor Ramil. Thank you for the project they have given us. Good luck’

*Halija, female participant*

Similarly, young people expressed the happiness they felt regarding being together and being part of a group. The majority of participants said that they enjoyed taking pictures together with their friends or family:

‘I am happy when taking pictures, together me and my classmates’

*Jessica, female participant*

‘I enjoyed also when we are writing together and I am also happy when we are doing something together’

*Jomer, male participant*

‘[I enjoyed] playing games and running and being together’

*Anonymous (from written evaluation forms)*

‘We are happy because we are helping each other. Because I was together with Jonel, Ronel and Jomer’

*Neljon, male participant*

‘I have become happy because all of us are together with my friends. We are all together taking pictures concerning malaria’

*Jeverlyn, female participant*

Photovoice helped to cement existing groups and friendships together but also helped form new networks of relationships. The participants, co-facilitators and I were all upset when the project was over and there was a strong sense that as a group, we would all miss each other. It is important to acknowledge this as a deeply positive but also potentially negative outcome of participatory research in general as, when groups are dismantled there can be a sense of sadness as expressed by some participants:

‘I was happy before but now I’m lonely because you are leaving. I’m lonely now the project is finished’

*Jobert, male participant*

At the end of the project, I printed all of the pictures that participants had taken over the 15 weeks and presented each student with a folder of their images. These prints were received with a lot of pride and excitement and photographs helped bond people together further as they were exchanged between participants and members of the community as gifts.

### ***10.1.3 Feeling less shy and more able to teach others new things***

One of the primary objectives of this study was to evaluate how photovoice could be used as a way for young people to pass on what they learnt in the process to others. By the end of the project, the majority of young people certainly felt that their engagement and the outputs that they produced enabled them to communicate what they knew about health and malaria with their family members. Although participants initially found the prospect of teaching others difficult, by the end, they all felt that this was something that they were now much better at:

‘Before, I cannot do any kind of announcements but right now I am able to make announcements. Like, if I had a picture of a mosquito then now I can explain that to other people’

*Ronel, male participant*

The majority of participants expressed this ability to teach in terms of feeling less ‘shy’. This is particularly significant in the context of Palawan culture as shyness is a normative and even valued personal trait, especially for young girls. As Macdonald

(2007) explains *metemen* (Palawano for meekness and mild manners) is ‘valued to a high degree, contrary to assertiveness and arrogance (*dakag*), which are the epitome of offensive behaviour’ (ibid.: 139). This is coupled with the relational way in which identity is created which means that older members of the family, particularly men, are not always likely to neither heed the advice of young people nor consult them in decision-making processes, including those related to health. Here, photovoice enabled young people to have both the *confidence* as well as the *means* to communicate what they had learnt with older members of their family including their parents and, more significantly perhaps, enabled parents to listen and learn. In the context created by the photovoice project, this was considered both appropriate and positive. This was the case for the vast majority of young people:

‘I have learnt also to teach people about what I have learnt in this project’

*Farazana, female participant*

‘At first I was shy but now I am able to teach the people about malaria’

*April, female participant*

The largely positive change in young people’s ability to communicate with others was reflected in questionnaire results. There was a statistically significant increase in the number of adults from the intervention group (although still less than half) that had heard information about malaria from young people compared to the control group (Figure 10.1).

**Figure 10.1 Table showing sources of malaria information that adults reported receiving.**

Sources of information on malaria	Intervention			control		
	Before <i>n</i> (%)	After <i>n</i> (%)	p-value	Before <i>n</i> (%)	After <i>n</i> (%)	p-value
Radio	29 (82.9)	26 (83.9)	0.912	30 (62.5)	32 (72.7)	0.296
TV	17 (48.6)	15 (48.4)	0.988	23 (47.9)	10 (22.7)	0.012*
Poster	16 (45.7)	15 (48.4)	0.828	21 (43.8)	12 (27.3)	0.100

School	23 (65.7)	21 (67.7)	0.862	33 (68.8)	26 (59.1)	0.335
Teachers	23 (65.7)	21 (67.7)	0.862	33 (68.8)	28 (63.6)	0.604
Adults	14 (40.0)	18 (58.1)	0.143	31 (64.6)	18 (40.9)	0.023*
Young people	<b>8 (22.9)</b>	<b>15 (48.4)</b>	<b>0.030*</b>	24 (50.0)	15 (34.1)	0.123
Health workers	29 (82.9)	27 (87.1)	0.632	42 (87.5)	37 (84.1)	0.639

\* Pearson's chi-squared (significant at  $P < 0.05$ )

More significantly, both young people and parents expressed, that as a result of their children's teaching, they were able to learn things that they considered to be 'new' or do things 'differently'. Again this was something that was welcomed and the favourable reaction that parents had to taking direction from young people seemed to be because of the unique circumstances and context created by photovoice. The idea that parents were exposed to 'new' teachings was perhaps surprising. I myself had witnessed many of the same messages being taught in other health-related campaigns initiated by the Rural Health Unit (RHU) and National Malaria Control Programme (NMCP) (as described in chapter 4). Furthermore, some of the practices that young people were advising others to do (and that participants reported they now did as result) were things that I had observed, and participants had reported in interviews and questionnaires, already doing in relation to malaria like sleeping under mosquito nets and cleaning their surroundings:

'I told them we need to use a mosquito net every night in order to avoid mosquito bites. Even my aunties told me 'thank you for informing us and giving us this new information so now we will obey you and sleep under the net'. I also told them 'oh aunty you know paracetamol and amoxicillin is not a medicine for malaria'. I also told my parents. I also told them to avoid mosquito bites to avoid getting malaria'

*Nornita, female participant*

'I also told my neighbours that if you sleep in the night then use a mosquito net. I told the very old ones. They said 'ah ok'. They didn't know that before'

*Neljon, male participant*

'This helped the whole family especially in my family because we are cleaning up the surroundings and sleeping under the mosquito nets now so it really helped us'

*Jonathan, male participant*

'I told my mother. I said 'mother we need to use a mosquito net regularly'. She said 'ok from now on I will use a mosquito net every night'. Yes we are doing that now . . . Also we need to plant herbal medicines. I told to my father. He said 'ok I will plant herbal medicines'. But I didn't see him do that yet'

*Vivian, female participant*

'Yes. I told my older sister and my mother to clean up the surroundings every day. They said 'Yea you are right, we will clean the surroundings so we can avoid malaria'. I also told my aunty paracetamol is not for malaria. These were new things for them also'

*Jeverlyn, female participant*

This disjuncture could be explained by many possible reasons. As described in part 1, malaria is used as a blanket term to describe a wide spectrum of illnesses and, as such, an equally wide spectrum of beliefs, knowledge and practices surround it. As described in the previous chapter, a variety of issues were discussed in our sessions and each participant gained different knowledge or skills in the process and then transmitted this to people who also held a very wide range of views or engaged in a wide range of practices. In light of this, what was considered to be 'new' or 'different' varied considerably between individual participants.

This is coupled with the fact that the official awareness campaigns delivered by the RHU and NMCP combine information on many febrile illness like malaria, dengue, urinary tract infections and sexually transmitted diseases. These are presented to audiences in

one 'lecture' style session. Many participants found these sessions confusing and, as a result, were not clear on the distinctions between malaria and other illnesses (no doubt contributing to the use of malaria as a blanket term) nor did they necessarily associate the objects and practices surrounding illnesses in general with any one 'disease'. As such, some participants told me that, even though they used mosquito nets to prevent mosquito bites, they associated this practice with many illnesses, not just malaria. One parent articulated why she felt the information from photovoice was 'different' to the other information she had heard:

'There were some people who are teaching about malaria before but not really emphasising it [alone]. Not like your project. It's really emphasised malaria and so has a lot of benefit for us'

*Mother of male participant Sabturin*

However, there are other reasons why participants may have considered the messages from photovoice more compelling, and therefore 'new', when compared to other projects. These concern the methodology itself. Participants (mainly adults) explained that the success of the project was due, in part, to the fact that the project was being conducted by me – a 'foreigner' whom they considered to be an 'international expert'. This could have made the knowledge created and transmitted by young people as a result of this project, seem somewhat more authoritative and legitimate.

More significantly, the nature of the knowledge that was being generated by young people, and then passed on to others, was itself considered by participants to be particularly engaging due to its visual nature. In evaluation interviews, young people said that it was the pictures directly that compelled them and others to learn and teach new things. They felt that this power of photographs was not something that they had necessarily given much thought to before doing the project. As these quotations demonstrate:

'It's better when there are pictures because you alone can read the pictures and get their meaning'

*Vivian, female participant*

‘[Pictures help you learn] because you can *see* the message in the picture . . . When you speak with a picture it is easier than when you speak without a picture. Because it helps you to remember [things], even things from the past’

*Farazana, female participant*

‘Me; Do you think using pictures helped you to learn new things?’

Participant: Oh yes.

Me: Why do pictures help you to learn?

Participant: When people are looking at the pictures they become happy. The pictures also help to prove the reality - they provide an example.

Me: Did you think that before?

Participant: No, only now we realised that pictures are so important’

*Jeverlyn, female participant*

Amongst those young people who did communicate what they had learnt with others, the ability to do so was particularly facilitated by the checklists that some of the students made. The vast majority of young people who made checklists reported using them to both guide their own practices as well as to explain to others the steps that they could take to stay healthy, as these quotes reveal:

‘Participant: I put it up on the wall in the front of the house. . . There were a lot of people gathered there just to look at the pictures. People asked ‘where did you get those pictures?’ I said ‘I got them from Miss Dalia’. There are a lot of people asking so I felt shy to explain to them all what that checklist was about.

Me: Did you do any new things as a result?

Participant: I allowed people to read the checklist I made. I clean up the surroundings and throw away dirty water from containers and throw away trash and burn it’

*Relan, male participant*

‘Participant: My mother said ‘what’s that? What is the importance of that?’ and I said to her ‘these are the things we were taking pictures of before’. I explained some of them and then we did some of those things like use a mosquito net and clean up the surroundings and throw away the stagnant water’

Me: Do you think that checklist is helpful for you and your family?

Participant: yes, definitely because now we do things differently’

*Sabturin, male participant*

‘Participant: I put it up in my house. My uncle read it. I explained to him what that checklist is.

Me: Did it change what you do?

Participant: Yes, like cleaning up the surroundings, making smoke regularly and allowing the spray man to spray the house’

*Jeverlyn, female participant*

As well as being a compelling way to both teach and learn, due to the visual nature of the information, participants also considered the images produced in photovoice to be authentic and directly relevant to their lives as they were generated by the participants themselves. As such, they produced something familiar to audiences with ‘real’ faces and places. Recognisable participants, parents, friends and neighbours were depicted enacting their lives in recognisable homes, gardens and the wider community. Images *showed* what audiences described as ‘reality’.

However, these largely positive outcomes were not uniform amongst all participants as some young people reported that they had not communicated what they had learnt with others. Some participants reported that even though they did feel less shy or had learnt new things as a result of the project, they still did not feel able (or inclined) to teach others new things. Furthermore, although the majority of young people reported



positive outcomes, this does not necessarily mean that all participants had the same experience or derived the same benefits. Young people are, after all, not homogenous groups, with similarities or connectedness determined simply by their similar age (Robson, Porter et al. 2009). This is significant and highlights an important point about participatory research with young people specifically but also research more generally: that the views, voiced by some children in research, cannot represent all children everywhere (ibid.).

Similarly, some adults reported that their children did not talk to them much about the project or that they did not see the outputs that they produced. This is reflected in the questionnaire data in which less than half of adult caregivers from the intervention group reported that had heard information about malaria from young people (Figure 10.1 above). In some cases, this was due to practical reasons as described by the father below but, in others, parents ‘forgot’ what their children had told them as described by the mother below:

‘Jayboy talked to his mother about things because many times I am away working . . . I did not go to the event because I was at work’

*Father of male participant Jayboy*

Me: Did Nelsa talk about the project?

Participant: Sometimes she is telling me about it.

Me: Did she tell you about any of the things she learnt?

Participant: Some of the things but I forgot already what’

*Mother of female participant*

#### ***10.1.4 Altering malaria-related health practice***

One of the primary aims of this project was to assess whether or not doing photovoice could affect how people *did* malaria in terms of altering malaria-related health practices. As described in the previous chapter, the nature of the photovoice method means that what each participant contributes to the project differs and reflects their own lived experience, knowledge and expertise. Similarly, what they then got out of the project is equally varied. This is exacerbated by the fact that, in this project, photovoice was conducted in five different groups and each group project took a slightly different course.

For example, in the process of putting together an exhibition, debates between young people took place regarding what their final messages were. Here, photographs stimulated young people to contest and negotiate with each other regarding their health realities. While a number of similar themes and issues arose across the five photovoice groups, in the end, the images that each group selected, and the associated findings, varied. In some cases, this meant that contradictory findings were given regarding the same kinds of images. For example, the issue of whether or not people can get malaria from drinking dirty water came up in two groups. While some participants felt drinking dirty water could cause malaria, others in both groups felt that mosquitoes were the only source of malaria. Both groups wanted to include pictures that related to this theme as they felt it was an important issue and found different ways of resolving their divergent views. The first group decided that because the majority in the group felt that you could not get malaria from dirty water, they would explain this in their caption:



'We cannot get the malaria sickness from drinking dirty water because what dirty water brings us if we drink it is stomach pain. Therefore, make it a habit that the water that you are going to drink is always clean so that we can avoid sickness'

*Group Rainbow*

Conversely, the second group were less resolute and decided on a less decisive caption:



'We can see in this picture a man drinking dirty water from the river and this is not good for the body. Many people believe that dirty water brings sickness of malaria. What I can teach to the people is that they can't have malaria through drinking dirty water alone. They will only have malaria if a mosquito also bites them. But still, it's not good to drink dirty water because you will suffer vomiting and you will get typhoid'

*Group Butterfly*

The other issue that was debated was that of medicines for malaria. While pictures of herbal medicine for malaria featured frequently in all group pictures and discussions, in the end, only three out of the five groups decided to include a picture and caption relating to these kinds of medicines. One such example is given below:



'In this picture you can see *pito-pito*. This is an effective medicine for malaria and it is planted beside our house. We boil *pito-pito* and then put it in the glass and drink it and the taste is acrid. We can teach the people that every family must plant *pito-pito*'

*Group Eagle*

The above example illustrates the major themes that emerged relating to herbal medicine - the majority of young people felt many kinds of plants were effective for malaria and, more significantly, that these were cheaper and easier to obtain compared to allopathic medicines. However, in two groups, there were a number of young people who did not want to include pictures of herbal medicines (although they had taken

many) as they felt unsure about what exactly some of the plants were for and some even felt sure that many medicines photographed were not for malaria but other ailments. In the end, these groups could not come to a consensus and the majority voted not to include images that related to this theme.

Consequently, although all young people reported that they had learnt something new about malaria, what this was varied between groups and even individuals.

For example:

‘Before, I thought that malaria came from dirty water but I made a mistake here because you can get malaria only from the bite of a mosquito. And also like herbal medicines, I thought before that they are a treatment for malaria but I am wrong’

*Rhea, female participant*

‘Yes, I learnt that is important to sleep under a mosquito net. Before, I did not have deeper knowledge of that before. I knew something about it but not a lot’

*Ronel, male participant*

‘I also learnt about throwing away trash. I was doing it before but I didn’t really know why’

*Jonel, male participant*

‘Yes – I learnt you should have a lot of animals in the house – to take care of a lot of animals so that mosquitoes will bite them and not the people’

*Nornita, female participant*

‘I learnt mosquitoes bite people and then you can get sick’

*Jobert, male participant*

'I learnt that garbage is where mosquitoes lay their eggs'

*Garry, male participant*

'Yes – to eat vegetables. Vegetables make you fat'

*Neljon, male participant*

This heterogeneity is also reflected in the questionnaire data (See Appendix three): there was no statistically significant difference in the perception of causes of malaria in either the intervention or control groups after photovoice nor in the correct identification of allopathic medicines for malaria. In terms of symptom recognition, there was an even more confused picture as there was a statistically significant increase in the numbers of young people that thought headache, loss of energy and vomiting were symptoms of malaria in the intervention group following photovoice. However, there was also a statistically significant increase in the numbers of young people that thought sweating, coughing, diarrhoea and diarrhoea and vomiting were causes of malaria in the control group. These inconsistencies are probably explained by the heterogeneity of experience of each participant, as mentioned above, as well as the relative unreliability of the statistics. Although the most commonly used (and therefore most comparable) cut-off point for significance (0.05) was used, this was combined with a relatively large number of tests (in which case an average of 5% of tests would appear significant). Together, these factors may have yielded less precise results.

As well as changes to knowledge, the majority of young people reported that, as a result of photovoice, they engaged in a number of new practices or that they carried out existing practices more regularly or for different reasons. As with knowledge, there was variation between groups and individuals regarding which practices were affected:

'Now I clean up the surroundings, make smoke regularly and know to allow the spray man to spray the house'

*Jeverlyn, female participant*

‘Since your project, I noticed some changes. I have seen her cleaning up the surroundings. If there is some stagnant water, she fixes the canal so that the water will flow’

*Mother of female participant April*

‘I learnt to use regularly the mosquito net. I wasn’t doing that before. Before, my parents were using the mosquito net but not me. Now I am using it every night. I didn’t explain to my parents, I just did it’

*Jonel, male participant*

‘From the time he was involved in the project, he is helpful now’

*Mother of male participant Sabturin*

‘Dirty water, I throw it away so there is no place for mosquitoes to lay their eggs. [I did that] just now, not before’

*Jonery, male participant*

In addition, many young people reported that their actions in communicating with their family members, friends and neighbours resulted in these people changing some of their practices but, again, what specifically changed varied between individuals.

‘Now we are using a mosquito net. Before we are not using them. We were only using them sometimes but now we use them more regularly. The whole family is now using them’

*Nornita, female participant*

'I told my mother. I told her to clean up the surroundings so that there is no place for mosquitoes to live and there is no-where for them to lay their eggs . . She said 'ok, let's go clean up together then'

*Jonathan, male participant*

These changes were also reported by some of the adults that I spoke to:

'We did number 6 [from the checklist] together – 'burn smoke always so that mosquitoes go away'. Also throwing away dirty water and using a mosquito net every night'

*Mother of female participant Nelsa*

'Yes, [I learnt] you need to clean up the surroundings like the garbage and the trash so that you can avoid the sickness of malaria. Because mosquitoes lay their eggs in the dirty trash so we need to burn them. Not just the trash but the places like that [points] we need to clean it up so that there is nowhere for mosquitoes to live. I have heard that from that programme you have there and I also I saw that in the pictures. Also Sabturin showed us his pictures and I saw pictures of dirty water so I know we need to clear dirty water to avoid mosquitoes having a place to live . . . We have been doing those things together like sleeping under a net and cleaning up our surroundings. Sabturin is the one who is helping me so much now'

*Mother of male participant Sabturin*

As with knowledge, this heterogeneity is reflected in the questionnaire data (See Appendix four). Within the intervention group, there was a statistically significant increase in the numbers of young people that reported draining stagnant water to prevent malaria, a decrease in those that reported going to the Rural Health Unit as their first action in response to malaria and an increase in those that reported telling an adult first as their first action. Amongst the control group, there were a number of statistically significant differences (in both directions) in terms of practices that young people reported doing in relation to both the prevention and treatment of malaria (See Appendix four). Again, as with knowledge, these apparently paradoxical statistical

results are probably explained by the combination of the relatively high number of tests using the most commonly used (and therefore comparable), but perhaps less precise, cut-off point for significance (0.05).

#### ***10.1.5 Young people's role in promoting health in relation to others***

A number of practitioners who have used photovoice have reported that engaging in the process 'empowered' participants by changing their sense of self. For example, some researchers have reported that photovoice led to increased levels of self-esteem (Miranda 2003; Strack, Magill et al. 2004; Wang 2006) and self-efficacy (Pritzker, Lachapelle et al. 2012; Russinova, Rogers et al. 2014).

As described in chapter 3, I used established scales to try and determine changes to both self-esteem and self-efficacy amongst young people before and after their participation in this project. Self-esteem is generally defined as 'a favourable or unfavourable attitude toward the self' (Rosenberg 1965: 15) and refers to a predominantly psychological perception of the self. In my questionnaire, I measured self-esteem using Rosenberg's Self-Esteem Scale (RSE). The RSE is the most widely-used self-esteem measure in social science research (Flynn 2003). It is an attempt to achieve a unidimensional measure of global self-esteem that is supposedly applicable cross-culturally (ibid.). It was designed to be a Gutman scale. This means that the RSE items represent a continuum of self-worth statements ranging from statements that are endorsed by individuals with low self-esteem to statements that are endorsed only by persons with high self-esteem. However, the scale is now commonly scored as a *Likert* scale meaning the ten items are answered on a four point scale ranging from strongly agree to strongly disagree (University of Maryland 2012). As described in chapter 3, the original RSE contains ten questions but due to the translatability of one question, I adapted it to include nine questions (See Figure 10.2).



**Figure 10.2 Survey questions used to determine self-esteem. Questions were adapted from the Rosenberg Self-Esteem Scale.**

<b>Self-esteem</b>	
<b>To what extent do you agree with the following statements?</b>	
<b>1=Definitely agree, 2= Agree, 3= Disagree, 4=Definitely disagree</b>	
1) On the whole, I am satisfied with myself	<input type="checkbox"/>
2) At times I think I am no good at all	<input type="checkbox"/>
3) I feel that I have a number of good qualities	<input type="checkbox"/>
4) I am able to do things as well as most other people	<input type="checkbox"/>
5) I feel I do not have much to be proud of	<input type="checkbox"/>
6) I certainly feel useless at times	<input type="checkbox"/>
7) I feel that I'm a person of worth, at least on a level equal with others	<input type="checkbox"/>
8) All in all, I tend to feel that I'm a failure	<input type="checkbox"/>
9) I take a positive attitude toward myself	<input type="checkbox"/>

Scores were summed up to yield the final composite score with a range from 0-36. No discrete cut-off points were cited in the original scale to distinguish high and low self-esteem so in my analysis I used mean composite scores as a point of comparison. Figure 10.3 and Figure 10.4 illustrate that there was no statistically significant difference in *mean* scores before or after photovoice in either the control or intervention groups.

However, Figures 10.3 and 10.4 show that there was a change to the characteristics of the *distribution*. In the intervention group, the *modal* value at follow-up was higher (18) than at baseline (15) suggesting an overall increase in self-esteem. Furthermore, although the range had increased in the follow-up group (to 18 from 15 at baseline), there is a bunching of values around the mean and a slightly smaller standard deviation in the follow-up group (3.46) compared to at baseline (4.12). In the control group, there was a similar bunching around the mean and a smaller standard deviation at follow-up (3.12) compared to at baseline (4.57). However, the modal value was lower in the follow-up group (21) compared to the baseline group (24). This suggests that, although not significant, there was a larger positive change in the *distribution* of mean self-esteem scores in the intervention group compared to the control group after photovoice.

**Figure 10.3 Table comparing young people's self-esteem score before and after photovoice.**

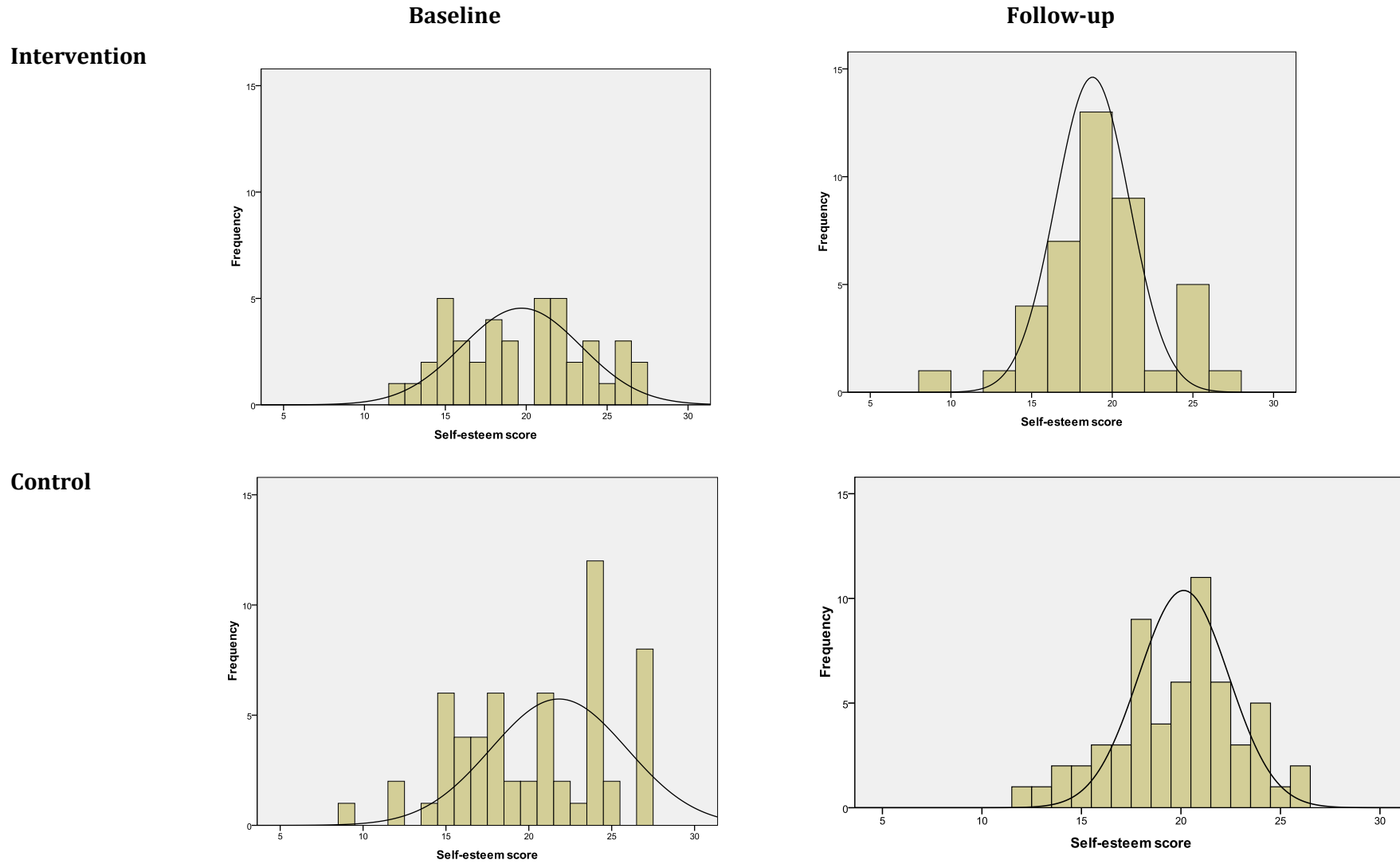
Young people	Intervention			Control		
	Before	After	p-value	Before	After	p-value
Young people's mean self-esteem score	19.74	18.74	0.160	20.37	19.81	0.364
Mode self-esteem score	15	18	N/A	24	21	N/A
Standard deviation	4.12	3.46	N/A	4.57	3.12	N/A

\* Wilcoxon Signed Ranks Test (significant at  $P < 0.05$ )<sup>10</sup>

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<sup>10</sup> The *Wilcoxon signed-rank test* non-parametric statistical test was used as the difference between the two variables is not normally distributed.

**Figure 10.4** Graphs illustrating young people's mean self-esteem score before and after photovoice.



The lack of statistical *significance* in questionnaire data related to self-esteem also runs counter to my findings from qualitative data. As described above, in follow-up interviews, many participants said that a major outcome of their involvement with photovoice was that they felt much more confident and outgoing during session as well as outside of them and that this was particularly related to teaching and communicating with others, especially older people like parents. As well as students' perceptions of themselves, teachers, some parents (and myself) noticed significant changes in the students who were part of this project:

'Yes, there are some big changes. Before, they were just observing in my classes, but now, they are *doing* more. Before they would run away from new people, even me for one week, they would run away from me when I came in the morning. I was upset of course, but slowly slowly they came to my lessons. Now, I see how when your other foreigner friend or other visitors came here they are not shy anymore'

*Teacher*

'I have noticed big changes in Sabturin's life because from the time he was involved in the project he is helpful now and there are big changes in his life . . He was a shy boy before but right now, he is confident. Mam Dalia's project is a big help because now he is confident in talking to people. Before he was a shy type and didn't want to mingle with others'

Mother of male participant Sabturin

'Before, if you asked her to sing she would not sing but now she is like a champion. Before she is shy but right now, you can let her sing'

*Mother of female participant April*

'I have noticed that Jayboy before was a very shy person but I followed up and told him 'don't always be shy. Explore education because maybe

you will be bright' and right now, I think he is no longer shy . . . You have made a big contribution to why he is no longer shy – that photo project contributed so much. Jayboy said to me 'I am very thankful to Mam Dalia because since I started to join her project I have become a little bit confident because I have opened my mind to the fact I do not need to be shy anymore and I myself can teach people things'

*Mother of male participant Jayboy*

More broadly, due to feeling more able to communicate with others, many young people felt that their *role* in promoting their own health as well as that of their families changed:

'My family, even my parents ask me how to be healthy. They did not do that before'

*Leo, male participant*

Me: Who is responsible for keeping you healthy?

Participant: Me, myself

Me: Do you think you can help your family to stay healthy?

Participant: Yes of course I have a role in that

Me: Did you always feel like that?

Participant: No I didn't feel like that before. After the project I feel I have a part to play

Me: Why?

Participant: Because lately I just know about health which has helped so much in the family

Me: Do your parents or family ever ask you about health?

Participant: Yes

Me: Did they do that before?

Participant: No, they did not do that before'

*Ronel, male participant*

These quotes clearly show that, as a direct result of this project, many of the young people involved felt 'less shy', more 'confident in talking to people', more able to 'mingle with others' and even able to 'sing'. These are concepts that imply improved self-esteem but are clearly not asked in the questions that make up the RSE scale (see Figure 10.2). These changes are *subtle, relational* and *context* specific and unlikely to affect the way that broader questions which ask about 'larger' scale issues like 'pride' 'satisfaction' and 'qualities' are answered. However, these outcomes are still likely to have had an overall effect on general self-esteem. Moreover, self-esteem, rather than being an abstract, individual and psychological state, emerges *interrelationally* with other actors in various settings: a critical point that is missed with the use of such measurement scales. As such, how people view themselves, ideals about what a person should be like and even what indicates feeling 'good' or 'bad' about oneself is culturally mediated. This poses a problem for the abstract concepts that are implied in the questions in the RSE scale like satisfaction, pride, equality and comparison with others. It is therefore problematic to try and objectively evaluate self-esteem through a standardised questionnaire.

These issues are also relevant to the quality of self-efficacy. In terms of assessing self-efficacy, similar methodological issues arise. In my questionnaires, I used the General Self-Efficacy (GSE) scale (Schwarzer and Jerusalem 1995) to assess self-efficacy which is a measure of how well individuals report that they can cope with daily life and various kinds of stressful life events. I used the ten questions that form the standard scale to assess general self-efficacy (see Figure 10.5). Participants were asked to respond with one of four choices, ranging from "not true at all" to "exactly true". Responses to all ten items were summed up to yield the final composite score, with a range from ten to 40.

**Figure 10.5 Survey questions used to determine general self-efficacy.**

<b>General self-efficacy</b>	
<b>To what extent are the following statements true?</b>	
<b>1=Not at all true 2=Not really true 3=Nearly true 4= Exactly true</b>	
1) I can always manage to solve difficult problems if I try hard enough	<input type="checkbox"/>
2) If someone opposes me, I can find the means and ways to get what I want	<input type="checkbox"/>
3) It is easy for me to stick to my aims and accomplish my goals	<input type="checkbox"/>
4) I am confident that I could deal efficiently with unexpected events	<input type="checkbox"/>
5) Thanks to my resourcefulness, I know how to handle unforeseen situations	<input type="checkbox"/>
6) I can solve most problems if I invest the necessary effort	<input type="checkbox"/>
7) I can remain calm when facing difficulties because I can rely on my coping abilities	<input type="checkbox"/>
8) When I am confronted with a problem, I can usually find several solutions	<input type="checkbox"/>
9) If I am in trouble, I can usually think of a solution	<input type="checkbox"/>
10) I can usually handle whatever comes my way	<input type="checkbox"/>

As well as GSE, the scale can also be used to measure Health Self-Efficacy (HSE) and assess its potential influences in initiating behaviour change. Luszczynska and Schwarzer (2005) recommend that, for health behaviour studies, it is actually not necessary to use larger scales if a specific behaviour is to be predicted. A rule of thumb is to use the following semantic structure: 'I am certain that I can do xx, even if yy (barrier)' (ibid.). For my questionnaire, I developed a further nine questions following this format in order to gather data on self-efficacy directly related to malaria (Malaria Self-Efficacy- MSE) (See Figure 10.6).

**Figure 10.6 Survey questions used to determine malaria self-efficacy.**

<b>Malaria self efficacy</b>	
<b>To what extent are the following statements true?</b>	
<b>1=Not at all true 2=Not really true 3=Nearly true 4= Exactly true</b>	
1) I am certain that I know how to recognise the symptoms of malaria without asking somebody else	<input type="checkbox"/>
2) I am certain that I know where to go to be treated if I have malaria without asking somebody else	<input type="checkbox"/>

- 3) I am certain that I know what medicine to take for malaria without asking somebody else [\_\_]
- 4) I feel confident getting medicines for malaria myself without asking an adult first [\_\_]
- 5) My parents trust me to get medicines for malaria myself without asking them first [\_\_]
- 6) I feel confident asking help from a health professional myself when I have malaria without asking my parents first [\_\_]
- 7) My parents trust me to ask help from a health professional myself when I have malaria without asking them first [\_\_]
- 8) I feel confident talking to health professionals when I am sick [\_\_]
- 9) I feel health professionals take me seriously when I talk to them [\_\_]

Figure 10.7 illustrates that there was a *fall* in young people's mean scores for both GSE and MSE after photovoice in the intervention group but this was not statistically significant. However in the control groups, there was a statistically significant drop in mean GSE score and a statistically significant increase in MSE score (see Figure 10.7 for p-values).

**Figure 10.7 Table showing young people's mean general self-efficacy and malaria self-efficacy scores before and after photovoice.**

Young people	Intervention			Control		
	Before	After	p-value	Before	After	p-value
Mean General Self-Efficacy score	29.83	28.90	0.396	30.54	28.02	0.014*
Mean Malaria Self-Efficacy score	20.05	18.82	0.377	20.61	23.51	0.011*

\* Wilcoxon Signed Ranks Test (significant at  $P < 0.05$ )<sup>11</sup>

Although these results suggest that photovoice might have brought about a decrease in self-efficacy (although not a significant one), it is questionable whether or not this is necessarily a 'negative' outcome when considered in the particular context of this setting. As described in previous chapters, Palawan society is characterised by collective interdependence as opposed to individualism and independence – characteristics which are implicit in GSE scale questions like 'When I am confronted with a problem, I can usually find several solutions', 'If I am in trouble, I can usually think of a solution' and 'I

<sup>11</sup> The *Wilcoxon signed-rank test* non-parametric statistical test was used as the difference between the two variables is not normally distributed.



can usually handle whatever comes my way'. Consequently, scales such as this are limited in that they only account for definitions of self-efficacy that align with these characteristics. As such, they do not take account of different culturally situated indicators of self-efficacy. Furthermore, it is questionable how meaningful self-efficacy is as a concept when selves are relational and group-based.

This is especially pertinent to the self-efficacy questions related to malaria as the focus of these questions was to ask young people whether they felt able to recognise symptoms and medicine and take action without asking their parents first. In the intervention group, there was a slight decrease in mean self-efficacy score. However, rather than a 'negative' change, this could instead be interpreted a 'positive' change. During photovoice many young people expressed the view that they should consult adults when they were sick particularly in relation to the use of allopathic medicines. This aligns with culturally-normative behaviour in the Palawan context which is strictly relational in nature and characterised by collective decision making. In this context at least, actions taken without consultation with an adult would be considered to be culturally inappropriate and run counter to conventions relating to decision-making.

This is also illustrated in the results from questions that relate to medicine use. Figure 10.8 summarizes changes in young people's use of medicines before and after photovoice and shows that there was a general *decrease* in the number of young people that reported buying and taking medicines without asking an adult first within the intervention group. There was a similar *decrease* in the number of young people that gave medicines to other people. Conversely, amongst the control group, there was an increase in the numbers of young people that gave medicines to other people. In this cultural context, and the more specific context created by photovoice, GSE and HSE that is individually focussed may not have been desirable. In addition, for safety reasons, it is questionable how far young people should be encouraged to take medicines without the guidance of adults. In line with this, the majority of young people interviewed in the intervention groups felt that they were more confident about their ability to positively affect their own health and that of their families. This suggests that acting in groups or in consultation with others is in fact preferable and actually contributed to their increased sense of efficacy. As described in chapter 8, in this context it may be more

useful to think of perceptions of the self as pertaining to relationalism (Robbins 2002); dividuality (Strathern 1998) and heteronomy (Sariola and Simpson 2011).

**Figure 10.8 Table showing young people's use of allopathic medicines before and after photovoice.**

Use of allopathic medicines	Intervention			control		
	Before <i>n</i> (%)	After <i>n</i> (%)	p-value	Before <i>n</i> (%)	After <i>n</i> (%)	p-value
Bought medicines alone without asking an adult	<b>18 (36.7)</b>	<b>7 (16.7)</b>	<b>0.033*</b>	17 (26.6)	13 (22.0)	0.559
Taken medicines without asking an adult	5 (10.2)	1 (2.4)	0.134	10 (15.6)	10 (16.9)	0.842
Given medicines to younger family members	18 (36.7)	10 (23.8)	0.183	24 (37.5)	32 (54.2)	0.063
Given medicines to family members of same age	16 (32.7)	11 (26.2)	0.501	24 (37.5)	30 (50.8)	0.136
Given medicines to older family members	17 (34.7)	7 (16.7)	0.052	<b>24 (37.5)</b>	<b>33 (55.9)</b>	<b>0.041*</b>
Given medicines to younger non-family members	<b>10 (20.4)</b>	<b>2 (4.8)</b>	<b>0.028*</b>	<b>8 (12.5)</b>	<b>22 (37.3)</b>	<b>0.001*</b>
Given medicines to non-family members of same age	10 (20.4)	3 (7.1)	0.071	<b>8 (12.5)</b>	<b>19 (32.2)</b>	<b>0.008*</b>
Given medicines to older non-family members	10 (20.4)	2 (4.8)	0.028*	8 (12.5)	20 (33.9)	0.005*

These findings are consistent with the idea of looking at the actions that people take as 'practices' as opposed to 'behaviours' in that they are wholly situated within the cultural context in which they occur. Seen in this light, photovoice was effective in altering young people's sense of self that, in turn, had implications for the actions that they took following photovoice. However, in order to interpret these changes, they must be viewed as situated in the context in which they emerged.

## **10.2 Conclusion**

In this chapter, I have described the agency of photographs, as material objects, and what the process of making them *did*. I have demonstrated how photovoice did go beyond simply allowing participants to depict different versions of malarias as it also had a potentially transformative effect amongst both the young people who created photographs and the people with whom they were shared. While these changes were often subtle, and, in some cases, counter to what was 'expected' from photovoice, examining them in context reveals that participants regarded these changes as positive. Significantly, in terms of malaria practice, photovoice altered the way in which young people not only thought about but also *did* malarias. Most crucially perhaps, as a result of engaging in the photovoice process young people's interactions with each other and their families changed as did their role in promoting health *in relation* to others.

## Chapter 11: How *doing* photovoice potentially alters *doing* malaria: *bodily* participation and empowerment

In this chapter, I provide an explanation for how and why *doing* photovoice potentially brought about changes to how malaria was *done* by offering a critical discussion of the feature which is regarded as the primary nexus of change in Participatory Action Research (PAR) - *participation*. Health practitioners conducting PAR aim to 'empower' people to positively change their health by increasing their participation, both in the research process, and in their health-related practices. Empowerment is defined as an individual's ability to have control over decisions that affect their own lives and participation is framed as a conscious, cognitive ability of the mind to be involved in the decision-making process. In a similar vein, current literature on photovoice suggests its success lies in its ability to engage participants in becoming 'critically conscious' (Freire 1973) about their life and practices, helping them to develop a clear, mental conceptualisation of a different future and then take increased cognitive control over decisions that affect their lives. However, this emphasis on knowledge and thoughts ignores the most basic way of thinking about participation – as an *unconscious* and *bodily* act of taking part in a process – of *doing*.

In this chapter, I apply a phenomenological approach and provide an analysis of photographs that document young people *doing* photovoice. Here, photographs become the unit of analysis as they help to *look for* participation and define *what* it looks like. I show how photographs reveal how photovoice requires people to participate *bodily*, not just cognitively, in both the research process and in their own health-related practices. As a result, I offer a critique of the current literature which suggests that photovoice encourages participants to participate in cognitive decision-making and therefore 'empowers' them to make changes to their lives by promoting cognitive, critical consciousness (Wang and Burris 1994; Wang and Burris 1997; Wang, Yi et al. 1998; Wang 1999). Instead, building on Bourdieu's (1977) notion of '*habitus*', I argue that photovoice encourages *bodily* participation because it builds on what Benjamin (1993/1999) calls our 'mimetic faculty' causing participants to engage in a somewhat unconscious, but potentially transformative, process of copying, copy-making and mimetic learning. Furthermore, photovoice engages all our *bodily* senses, eliciting

emotions including a sense of fun. The embodied nature of participating and doing means that people engage not just through their cognitive, thinking minds but also through their corporeal, feeling bodies. The emotional engagement that photovoice promotes is therefore crucial to the bodily transformation that it fosters. Bodily participation in photovoice is also potentially transformative because it is an inter-subjective process that occurs in groups, not just on an individual level. In doing so, photovoice attends to the inter-subjective and relational nature of doing by creating groups of practicing beings. By re-thinking participation in the photovoice process, I offer a critique of the current theoretical understanding of photovoice and provide an alternative explanation for how it, as a method, can potentially *bodily* empower people to alter their health-related practice.

### **11.1 Empowerment through participation: what we are looking for?**

Empowerment in health has been linked with better outcomes for young people in a range of settings (Wallerstein 2006). Much of the literature on photovoice makes the claim that it, as a method, empowers participants to ‘determine how the project unfolds’ (Wang and Burris 1994: 172) as well make changes in their lives that no longer ‘foster dependency’ (ibid.). Although a wide range of photovoice studies cite individual, youth or community empowerment as an outcome of their projects (See review by Catalani et al., 2010), the definition of empowerment is varied, making an assessment of it difficult. As Cook (2012) explains, the use of common terminology and naming creates an ‘illusionary consensus’ (ibid.: 2) about what something is, how it should be brought about and what it is expected to achieve. In order to establish how and to what end photovoice facilitated young people’s empowerment in their health, there is a need to consider more clearly exactly what is meant by ‘empowerment’ in order to overcome the conceptual ambiguity that surrounds the term.

Discussions of how to characterise youth empowerment are varied but the definition provided in a recent review by Morton and Montgomery (2011) epitomises the most popular conceptualisations:

‘[Empowerment is] a non-static process often characterized by different levels of participation at different levels of decision-making’

(ibid.: 10)

Here, power equates to the cognitive act of decision-making and suggests that empowerment is intimately tied up with an individually-orientated idea of the self. Current definitions of empowerment have moved beyond hierarchical conceptions of scales or ladders where increased levels of participation in decision-making determine movement from one rung to the next, leading ultimately to empowerment (Tisdall and Liebel 2008). More recent definitions converge on the idea that participation oscillates throughout the research process and can involve sharing or even allowing decision-making power to reside with others including researchers (see review in Hampshire, Hills et al. 2005). However, these definitions still rest on the same fundamental underlying principal: that the aim of participatory research is to enable young people to participate in making *decisions* that affect change in their lives (Morton and Montgomery 2011). This is what McTaggart (1997) describes as ‘authentic participation’ (ibid.: 28 cited in Cook 2012). Participation is framed as a deliberative and cognitive act and increased discourse and reflection are considered the primary vehicles for achieving empowerment and changing practice (Beratan 2007).

Accordingly, with regard to photovoice, many authors refer back to seminal works by Wang which cite the centrality of Freire’s (1973) work on critical pedagogy and problem-posing education for liberation and suggest that this is the nexus for change in photovoice (Foster-Fishman, Nowell et al. 2005; Carlson, Engebretson et al. 2006). Central to Freire’s work is the idea of ‘critical consciousness’ which has become ‘synonymous with the philosophy of empowerment and participation in public health and community development’ (Carlson et al., 2006: 838). In his work with illiterate and marginalized participants in Brazil, Freire advocated shifting power dynamics between teacher and learner so as to engage both groups as ‘co-creators of knowledge’ (cited in Carlson et al., 2006: 837). Through the process of ‘problem-posing’, Freire believes learners reach a stage of *conscientization* where they have increased levels of critical consciousness. In time, when combined with conscious action (*praxis*) subjugated people can overcome social oppression by having more control over decisions that affect their lives. For Freire, there is a direct relationship between how people interpret, think and talk about their reality and how they practically respond. Consequently, many photovoice practitioners uncritically refer to decision-making as the parameter

with which to measure participation and document where control over this lies at various stages of the photovoice process including the action people take in their lives following photovoice.

However, these kinds of definitions focus on the *outcomes* of participation and ignore the most basic way of thinking about participation – as a *process* of taking part and sharing (Tisdall and Liebel 2008: 2) – of *doing*. To counter this, here I take a processual approach to participation and focus on the *practice* of taking part. I believe that by focussing on the process of participating we can learn something new about what it really means to be engaged *in practice*.

### **11.2 Looking for participation**

In this section I will describe the method of *looking for* participation in a photovoice project. In the next section, I will document what participants were seen doing at various stages of the process and later suggest that this *doing* is the mechanism by which they achieved control and ownership of these processes and of their own practices.

Defining participation is one thing but achieving it in difficult, ‘real-life’ field situations is quite another (Vaughn 2011) as is establishing ways to evaluate how successful attempts are. To break this down, when I talk about the PAR process, there are two areas that I am interested in examining the levels of participation in. On the one hand, I will look at how far participants participated in the actual photovoice research project and on the other hand, how far they participated in the action that they took as a result of photovoice – in this case actions related to malaria-related health practices.

The primary source of data for this analysis is photographs themselves – either taken by participants or by myself. Mitchell (2011) describes how an important source of data in a photovoice project can be the images taken by the researcher to document the process – what she calls ‘visual fieldnotes’ (ibid.: 136). This visual evidence is part of what Fiske (1989) calls ‘production texts’ which he distinguishes from the immediate visual text (drawing, photographs, videos with/without captions or statements etc). Production texts refer to how participants describe the images and text regardless of whether or not they are engaged in producing visual data. Production texts are usually elicited in

follow-up interviews and can also include secondary visual data like the researcher's images of participants engaged in the study (cited in Mitchell 2008:367). For Mitchell (2011), these images provide evidence for engagement and by analyzing participants' facial expressions, body language and positionality suggests we can learn something not only about the process of photovoice but also potentially about how it can lead to social change (ibid.).

Inspired by Mitchell's work, I too looked back at the images of the photovoice process in order to look for participation. My data came from images I took with my own personal camera as well as a whole catalogue of images that I had initially discarded into a folder on my computer that I considered 'non data'. These images were taken by participants themselves but in the first few photovoice sessions where the emphasis was on learning to use cameras. Many of these images 'accidentally' depict young people using cameras for the first time (i.e. when I asked young people to press the capture button and they unintentionally took pictures of others opposite them doing the same thing) or carrying out initial exercises in the school grounds. Building on Mitchell's (2011) work, I am interested in what young people are doing and what they look like in these pictures in terms of their participation and engagement. This helps to move away from trying to measure youth engagement 'after the fact' and towards exploring the 'moment of engagement' (ibid.: 153).

In terms of the photovoice project itself, there are several potential sites for participation to be evaluated. Wang, Yi et al. (1998) encourage researchers to critically evaluate the level of participation in a photovoice project from the very beginning in terms of participants' inclusion in the process of designing the project and its focus. This was not entirely possible in this project as I was constrained by requirement of my PhD which was funded by a UK Research Council. Consequently, it was a requirement that I set out objectives of the study and the methods I intended to use before I went into the field. Furthermore, I specifically wanted to evaluate how participatory methods could be used as an intervention for malaria prevention and control so the decision over content was not an open process. As described in chapter 9, young people did not have a clear idea of the potential of the method or the kinds of outputs they could produce so this too was largely governed by me and restricted by time and funding available. Rather than assessing how far participants made decisions about the method, content of



research or outputs chosen, I am more interested in how different stages and process facilitate young people's participation and what can be learnt about the nature of this participation.

### **11.3 A phenomenological approach**

Central to the analysis in this chapter is the application of a phenomenological approach in order to try and understand human practice and experience. A rationalist philosophical underpinning implies that the mind and body are separate entities. For example, Descartes posited that thought and modes of thought are functions of the incorporeal mind while extension and modes of extension are properties of the corporeal body. As a result, human beings are conceived of dual, incorporating both subjective minds and objective bodies at once. Furthermore, the world and its material constituents are, like the body, objectified and thought to exist separate to any human conception of them. As a result, both the body and the world are pacified and only made meaningful by the intuition of the mind (Iskander 2006). No explanation is offered as to *how or why* meaningful judgements of the mind are formed. Sensory functions of the body are afforded no role in the construction of our judgments nor are the manifestations of relationships we form with objects (culture). Sensory experience and culture therefore remain illusory to some extent (ibid.).

These implications of Descartes' *Cogito*<sup>12</sup> have been somewhat resolved by embodiment and phenomenology. The philosophy of embodiment follows Heidegger's notion of *Dasein* (being-there whose being is in each case my own) and suggests that human beings are existents *within* the world. They interact and are embedded amongst all other things and experience the world through the perception of their *own* bodies. In this way, the mind, body and world are united and made inseparable. My analysis follows Merleau-Ponty (1962) and starts with the body-subject. Significantly, I consider the lived experience of body-subjects and focus on how bodily perception informs and creates meaningful experience.

Embodied experience is my starting point for analysing how young people participated in photovoice. Csordas (1993) defines embodiment as the requirement 'that the body be

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<sup>12</sup> The supposition that 'I think therefore I am'

understood as the existential ground of culture-not as an object that is “good to think”, but as a subject that is “necessary to be.” (ibid.: 135). The application of phenomenology to participation shifts the focus of away from largely mental/cognitive processes like knowledge, control, ownership and initiation (the outcomes of participation), towards an exploration of *how* and *why* these conditions take place. In doing so, the aim is to learn something about the *mechanisms* through which human beings can come to make changes to their condition.

#### **11.4 What does participation look like?**

In the following section, I describe what participation looked like at various stages of the photovoice project including the act of taking pictures, looking at pictures, meaning-making and participating in health-related practices.

##### ***11.4.1 The act of taking pictures***

The images below (Figure 11.1) were taken by participants in the first photovoice sessions where they were introduced to cameras and took pictures for the first time. After demonstrating the display screen and the capture button, I asked young people to try taking a picture for themselves. While these are only a small selection of these images, they illustrate some common themes that have arisen from an analysis of these photographs.

**Figure 11.1 Photographs showing participants taking pictures for the first time.**  
**Source: photovoice participants.**



These ‘accidental’ images reveal that young people copied my practice in order to fully engage their own bodies in the process of taking pictures. All of the participants are actively lifting their arms to hold their cameras up in the air and focussing their eyes at the screens whilst taking pictures. Some have turned their bodies in order to capture what they want, most notably the two boys in picture 1 (top left). In these images, the subjects are largely unaware of the fact they are being photographed as this was the first time they had taken pictures and were concentrating on their own cameras and what they were taking a picture of. These pictures showed many young people who I observed as being rather ‘disengaged’ in normal class and were reported as being so by their teachers. Giving them a camera meant that they had to move or modify their bodies in order to take part in the process. Even the teacher standing behind one of the pupils (picture 3, bottom left), while not actively participating, is entirely drawn into what is happening, as he lowers his body to fix his eyes upon what the girl is taking a picture of. Using a camera to take pictures draws the *body* to attention, not just the mind as young people copied me and each other in order to learn this new skill.

Taking part in this way was in some ways transformative as it meant that existing norms of relatedness were transcended. Many pictures revealed that there was a gendered element to how young people interacted with each other as, even though we worked in mixed groups, boys and girls immediately positioned themselves together into gendered groups and physically increased space between themselves and members of the opposite gender by moving their chairs further away. This mirrored wider practice in the school and other social contexts where boys and girls sat and socialised separately. However, the images selected below (Figure 11.2), reveal that when taking pictures, boys and girls felt comfortable interacting with each other. Here, their bodies turn towards rather than away from each other. Picture 2 (middle) also shows how young people felt comfortable taking pictures of older members of the group. This is particularly significant in Palawan culture where age is an extremely important social force in determining hierarchies and therefore interactions between people. This suggests that a camera can simultaneously act as an extension of the self (as described below) but also provides a means through which different norms and ways of being can be enacted.

**Figure 11.2 Photographs showing participants taking pictures of each other.**  
**Source: photovoice participants.**



#### ***11.4.2 Picturing the self***

In addition to taking pictures of each other, young people almost immediately after learning how to take a picture, outstretched their arms just above eye level and turned the camera round in order to take a picture of themselves. This happened largely

spontaneously in all groups. The act is captured in some young people's images shown below (Figure 11.3).

**Figure 11.3 Photographs showing participants taking pictures of themselves.**

**Source: photovoice participants.**



It is important to note that the resulting images (Figure 11.4) are not what could be conventionally described as a self-portrait in the Western sense of the word. This was the first time young people had used a camera and were consequently not entirely sure what effect they would produce nor can it be said that they were consciously trying to represent themselves in a particular way. They did not edit these images and did not know how to delete them so have little choice over what we, as the audience, now see and how these images now represent them. These images are on the whole out of focus, compositionally unconventional (in the tradition of Western photographic styles) and capture rather ambiguous expressions. This contrasts with the phenomenon of the 'selfie' which has attracted a lot of attention in recent years alongside the explosion of social media; pictures ostensibly taken of the self that are largely created for others to see.

Rather than being *ideal* or even *conscious* representations of the self, these images capture something else – a broader and almost compulsive (Benjamin 1993/1999) human interest in mimicry. This desire to imitate seems intuitively to apply not just to things that exist external to us as human beings, but in copying ourselves, our bodies, our being. The camera allowed young people to produce a copy of themselves which provided evidence of the self being there, participation in the action. Young people



willingly put themselves in the picture. In doing so, these images contribute to young people's active construction of their embodied self. There was certainly a large amount of joy and amusement expressed when young people looked at these images for the first time. Both Sontag (1979) and Barthes (1993) agree that one of the great powers of images is their ability to make something stand out – or what Barthes refers to as *punctum* - 'this element which rises from the scene, shoots out it like an arrow, and pierces me' (ibid.: 26). It is in the moment of seeing themselves that young people added to their understanding and construction of themselves.

**Figure 11.4 Photographs participants took of themselves. Source: photovoice participants.**



### **11.4.3 Looking at pictures**

Once young people produced photographs, the material objects became the main focus of sessions and interactions. The materiality of the photograph is important because, as Edwards and Hart (2004) explain, 'photographs exist materially in our world as

chemical deposits on paper, as images mounted on a multitude of different sized, shaped, coloured and decorated cards, as subject to additions on their surface or as drawing their meaning from presentational forms such as frames and albums' (ibid.: 1).

The pictures below (Figure 11.5) were taken by me and show young people from two groups looking at their own pictures, the first time they have been printed and distributed. Young people's eyes are intently fixed on the objects and viewers seem fully engaged in the act of looking. However, what is important here is that the interaction young people have with photographs cannot be reduced to a visual comprehension of the image alone. The images are not just looked at but *perceived* by the whole body. The act of looking cannot really be separated here from the act of touching as all the young people are handling their images, bending their fingers around them. Rather than being motionless, young people are in movement as their arms move the objects around on the table and tilt their heads and even backs towards the images. Some are smiling but all certainly look like they are furrowing their brows as they concentrate on the images. The photograph has certainly in this way, grabbed the attention of their on-lookers.

**Figure 11.5 Photographs showing participants looking at their own pictures for the first time. Source: author.**



In the photograph we are presented not only with an image that bears a visual resemblance to something located outside of it but also with a completely new physical object. However, a visual bias leads us to often focus on the perceived representational relationship, based on visual properties, between the copy and its model. In doing so we elevate the status of this visual information and promote meaning-centred approaches

aimed at trying to understand what images show and the meaning behind what they depict. Furthermore, these approaches tend to be accompanied by other visually driven metaphorical understandings of the world such as narrative and textual analysis.

What the images above reveal is that looking at images cannot simply be described as just looking at all. As young people participated, they are engaged fully in a holistic bodily act. Images copy only some of the original visual properties of their subject and strip that which they capture of their other sensorial characteristics like smell, feel, dimensionality, noise etc. Photography divorces its subject from one spatial or temporal milieu and imprints a copy of it upon a new, movable, material object. In its creation of a totally new entity, photography invites us to touch smell, taste, hear, see and feel a completely different situation to the one that paradoxically it wants to bring us closer to. In our engagement with a photograph, we never simply see its contents alone but rather all other aspects of the object itself; the paper, glass or metal the image is backed onto; the frame that borders it; the book or newspaper it is printed on etc.

Furthermore the act of perceiving photographs is never divorced from our perception of the whole world around us. We never simply experience photographs alone as at the same time, we experience the desk we sit at; the chair we sit on; the smell of the room; the light from the window; screaming young people in the background. The photograph then, doesn't *copy* a piece of the world but adds to its creation by allowing new sensorial experiences to take place an unlimited number of times by an unlimited number of people in an unlimited number of contexts. In this way we come, not to just *see* the contents of photographs, but *perceive* photographs - as whole objects in our total sensorial feeling of both the intangible and tangible properties they convey.

An interesting aspect of photovoice is that participants are increasingly using digital cameras which mean that photographs can be replicated in a number of new formats. This was certainly true of the project I conducted. Below are images (Figure 11.6) of young people looking at pictures on their cameras, on a computer screen, on a projector screen and in different mediums such as large laminated prints used for the exhibition. The question is whether or not these new forms alter the bodily engagement young people have with images and if so, in what ways?



**Figure 11.6 Photographs showing participants looking at pictures on their cameras, a computer screen, a projector screen and on paper. Source: author.**



As material objects then, the photographs produced in photovoice, become important, not simply because of their meaning (i.e. because of their content) but because of their role as social agents that, imbued with agency, ‘do’ (Gell 1998). Mitchell, takes this emphasis on agency even further and suggests that pictures are animated beings with their own sense of personhood that results in them having their own desires and needs. Consequently, pictures potentially ‘want’ to inspire some kind of change in their onlookers (2005).

#### ***11.4.5 Participating in meaning-making***

Conceiving of photographs as objects with social lives (Appadurai 1986) shifts the focus onto what photographs *do* rather than what they *mean*. This is significant when looking

at what happened when young people began to use their pictures in the photovoice sessions.

The first time I asked young people to use pictures in an exercise, they were using ones that they had not taken themselves. Initially, I asked participants to appoint a group leader to lead the task. Some young people volunteered themselves for this leadership role while others were appointed by the group. The creation of roles within the group resulted in leaders participating much more than other group members who took more of a back seat. This is reflected in some of the pictures I took of this session which are shown below (Figure 11.7). Here, we can see leaders engaging directly with pictures as they are the ones shown sorting through images, holding them up to show to the rest of the group, placing them into groups and sticking them to the wall for the exhibition. Many other young people in the group, rather than being attentive to what is going on, appear bored, disengaged or simply standing back and observing the action. In this case, bodily participation with material objects was only for a limited few and conferred power to some whilst taking it away from others.

**Figure 11.7 Photographs showing participants using pictures in sessions. Source: author.**





When it came to explaining the meanings behind images to the rest of class, it was noticeable that many young people who were not 'leaders' could not give meaning to the images, nor explain the rationale behind their inclusion in their exhibition. This suggests that there is a link between the bodily act of participation, meaning making and the potential for images to have an impact. Being present but passive, was arguably not enough to allow young people to come to an understanding of what pictures were showing, what they meant and therefore benefit from their transformative powers.

Following on from this session, I did not ask young people to appoint leaders in group work and this was much more successful in allowing more young people to actively participate in sessions. As described in the previous chapter, when it came to young people looking at their own pictures, the fact that the images were printed out meant they had to actively sort and share pictures and were all required to put up their own exhibition pictures. Furthermore, young people actively engaged in contextualising their images and took part in the act of writing or thinking about meanings and then communicating these to the class. These aspects are shown in the images below (Figure 11.8).

**Figure 11.8 Photographs showing participants contextualising their images.**  
**Source: author.**



When engaged in the act of communicating the meaning of their images to the group, young people stood in front of the group, often holding pieces of paper with their notes on in their hands and spoke out. Young people found this to be the hardest aspect of photovoice to begin with but over time, with repeated practice, they felt more and more able and comfortable to do this. In fact, young people reported that the skills of 'speaking in front of people' or 'standing at the front' were things they most enjoyed and felt they learnt in the process. The act of meaning making involved actions like articulating ideas, speaking in front of others, listening to others and explaining images through actions (like pointing).

Again, in the production of outputs, young people engaged in the process by deciding what outputs they wanted to produce and then actively making them. While all young people were involved in making the final exhibition, checklists and posters, they were given more choice regarding their participation in other activities such as the making of the film and the community event. In this case, young people volunteered if they wanted to do things like write the script, act in the film, present at the event etc and some (although a few) decided not to partake in any of these activities. This points to an important aspect of participation, that it cannot be reduced to a concept that applies to all participants, to the same degree at all times. Although the participants were working in groups, the group was made up of individuals and some participants were more able or inclined to participate than others and even to take on leadership roles. Other young people faced greater constraints to their participation than others. Rather than being on



some kind of ladder of progress throughout the whole process, young people fluctuated in terms of their participation and engagement.

These images reveal that bodily participation varies at different stages throughout the process. While many activities and decisions were initiated by me, this did not prevent young people from taking part and in some cases, they were able to lead their activities and their own actions. As described above, young people should not be viewed as a homogenous group of participants as their level of engagement fluctuated throughout the process. The point is to assess what opportunities for engagement photovoice provided and what form this took. This reveals something about why photovoice facilitates change.

#### ***11.4.6 Participating in doing malaria***

As well as engaging young people bodily in the project, photovoice also facilitated young people's bodily participation in their own health-related practices. In other words, *doing* photovoice, meant young people also *did* malaria. Many young people photographed each other or even themselves engaging in real malaria-related practices. The examples below (Figure 11.9) show young people enacting practices like sleeping under nets, disposing of rubbish and taking medicine and taking a bath.

**Figure 11.9 Photographs showing participants enacting malaria-related health practices. Source: author.**





In taking photographs, participants produced copies or versions of their health realities which were then re-framed/re-versioned again through the construction of oral and textual narratives.

However, participants didn't just catch each other enacting 'real-life' practices. As described in the previous chapter, many young people also reported specifically staging or imitating some practices if they felt these were things they could not serendipitously capture. For example, in Figure 11.10, the image on the left shows young people enacting cleaning their surroundings to deter mosquitoes, while the image on the right shows a young boy imitating cleaning his surroundings:

**Figure 11.10 Photographs showing participants enacting and imitating cleaning their surroundings to deter mosquitoes. Source: author.**





In Figure 11.11 below, the image on the left shows a child who is sick with fever and chilling in bed but the one on the right depicts a young girl imitating having these symptoms:

**Figure 11.11 Photographs showing participants enacting and imitating being sick with fever and chilling. Source: author.**



In Figure 11.12 below, the image on the right shows the siblings of the participant who took the picture asleep under a mosquito net at night whilst the participant who took the picture on the left asked their sibling to pose under a mosquito net during the day.

**Figure 11.12 Photographs showing participants enacting and imitating sleeping under a mosquito net. Source: author.**



This process of enacting and imitating reality and then making copies (mimetic objects) in photographs, narratives and text was particularly heightened in the process of making a film in which young people acted out for example, the sick role, the roles of

healers and even the roles of malaria-infected mosquito as shown in the images below (Figure 11.13):

**Figure 11.13 Photographs showing participants imitating roles (of the sick, the healer and the mosquito) during the process of making a film. Source: author.**



In the making of the film, young people repeatedly pretended to do the very practices they were advising themselves and others to do like disposing of rubbish, creating smoke to repel mosquitoes and having blood smears as shown in Figure 11.14 below.



**Figure 11.14** Photographs showing participants imitating health practices during the process of making a film. Source: author.



During this process, young people were no doubt thinking cognitively about their practices and the meanings behind them in order to create mimetic copies of them. However, in interviews, young people commented repeatedly that it was the *doing* that was also important and in general, made far less mention of the thinking that they engaged in. In this way, photovoice encouraged young people to participate in enacting embodied practices, as well as imitating them and re-presenting them in different forms through producing a range of mimetic objects like photographs, narratives, text and film.

### **11.5 Rethinking participation as a bodily not cognitive process**

Above, I have tried to highlight the need for researchers to refocus their attention on the ways in which their methods and strategies facilitate participation as a process, *look for* it and define *what* it looks like. I have documented how the process of producing and

using images is an embodied process that participants bodily engage in. In the next section, I document *how* and *why* photovoice encourages this bodily participation. By rethinking participation in the photovoice process, I provide an alternative explanation for the mechanisms through which human beings can be potentially influenced to alter their practical condition – to *do* differently.

### ***11.5.1 Acquiring unconscious habitus***

Throughout this thesis, I have emphasised my interest in exploring what people do, and by extension, how this might potentially be altered. However, the critical question is *why* people do what they do. This is a question that is at the core of anthropology and one that centres on the relationship between society (structure) and people (agency) and, crucially, what is it that mediates the two. Throughout this thesis, I have shown how external, objective societal structures and internal, subjective human agents are brought together through the mediating factor of *embodied* practice. Here, I take a deeper look at the nature of this embodied practice in an attempt to explore how it can be altered. In particular, I turn to the role of the unconscious. This is a topic which is somewhat controversial in the social sciences (Akram 2013) and often neglected in health-related research. The relative (de)merits of various arguments are beyond the scope of this thesis. Rather, here, I focus on Bourdieu's (1977) conception of the role of the unconscious in practice and highlight some of the key features of his argument to illustrate what makes it compelling as an explanation for how practice can be altered.

In his *Outline of a Theory of Practice*, Bourdieu (1977) criticises objectivism in which objective structures and subjective agents are divorced. Within this framework, structure exists apart from individual agency, determining human activity from the outside in or top down (Veenstra and Burnett 2014: 190). Instead, Bourdieu (1977) takes a relational approach and suggests that structure and agency are equal and both possess causal powers. Bourdieu (1977) unites the two in what he calls '*doxa*': where the social and natural become a self-evident, taken-for-granted understanding that people have of their place in the world in 'a quasi-perfect correspondence between the objective order and subjective principles of organization' (ibid.: 164). In Bourdieu's conception, *doxa* comes about when there is coherence between subjective actors who are attuned to the rhythms and regularities (Bourdieu 1990) of the objective structure in which they operate. To use Bourdieu's terms, there is unity between subjective

*'habitus'* and objective *'fields'*. According to Bourdieu, social actors exist within different *'fields'*: *'social arenas endowed with a specific gravity and force that influence the actions and reactions of social actors who have tacitly agreed to the rules of the game'* (Veenstra and Burnett 2014: 189). Embodied actors acquire an unconscious *'feel for the game'* (Bourdieu 1990) or competence (capital) as they become endowed with *'habitus'*:

*'the durably installed generative principle of regulated improvisations, produces practices which tend to reproduce the regularities immanent in the objective conditions of the production of their generative principle'*

(Bourdieu 1977: 78)

*Habitus* then refers to the *'social dispositions and beliefs acquired and stored by social actors over time as they move through social space, encounter different people and fields and reason their way through complex situations'* (Veenstra and Burnett 2014). Crucially, the relationship between field and *habitus* is not one of determinism as both rely on the existence of each other. As Veenstra and Burnett 2014 explain:

*'Neither habitus nor field has the capacity to explicate social action on its own – each must be understood in relation to the other. The field infuses habitus with its tendencies and rhythms while habitus contributes to constituting the field with value and meaning . . . In this way, when habitus encounters a social field of which it is the product it is like a fish in water; it possesses a practical sense in the field'*

(ibid.: 192)

In essence, Bourdieu dissolves the deterministic distinction made between structure and agency where practices are seen as *'no more than the acting-out of roles, the playing of scores or the implementation of plans'* (Bourdieu 1980: 52) and practice passively records known structures. Conversely, Bourdieu subverts this by suggesting that *habitus* is the mediating factor between the two and shapes dispositions and practices and allows for structures to be embodied. In this way, *'both habitus and social structure are continually reconstituted over time'* (Akram 2013).

Through his emphasis on *habitus*, Bourdieu gives less weight to agential reflexivity (internal dialogue) as the mediating factor between structure and agency. In other words, he de-emphasises the extent to which structure is able to influence human agency due to humans' ability to *consciously* deliberate on and evaluate structures in order to define their beliefs and attitudes and act in accordance. In opposition, Bourdieu suggests that embodied human *practice* (*habitus*) mediates structure and agency and crucially, that this can be either conscious *or* unconscious as 'each agent, wittingly or unwittingly, willy nilly, is a producer and reproducer of objective meaning' (ibid.: 79).

*Habitus* has this dual un(conscious) quality because it is brought about by complex interaction between an individual's largely unconscious free will on the one hand and social structure. Over time, structures become embedded - habitual - and reflexive thought takes a back seat to the unconscious. It is important to note that actors are not 'unconscious' in the sense that they lack awareness but more that their free will lacks 'explicit reason or signifying intent'. Rather than being primarily reflective, human practice is *embodied* and as such 'reflexivity, intentional actions, habit and the unconscious can all operate in conjunction with each other, and one does not cancel out the other (Akram 2013: 57).

For Bourdieu then, practice is created and reproduced largely unconsciously, 'without any deliberate pursuit of coherence... without any conscious concentration' (Bourdieu 1977: 170) and unfolds largely unnoticed. Changing practice is difficult because it is 'beyond the grasp of consciousness, and hence cannot be touched by voluntary, deliberate transformation [and] cannot even be made explicit' (ibid.: 94). Following on from Bourdieu, others have emphasised that although difficult to change, *habitus* 'is not fixed or permanent, and can be altered under unexpected situations or over a long historical period' (Navarro 2006: 16) as new *habitus* is acquired. While many authors have theorized that the route to changing *habitus* lies in making people more conscious of their position in society and actions (i.e. by encouraging agential reflexivity), I suggest instead, that facilitating *unconscious* practices could be an equally compelling way to alter practice. It is important to note, as Akram (2013) does, that this change in emphasis does not exclude agents' capacity for reflexive, intentional and conscious choices. Rather, it affords the unconscious a more active role in agency and sits alongside (not in conflict with) reflexivity and intentional action (ibid.).

Here, photography had a potentially transformative effect, not just because it made participants consciously think differently but because it also made them unconsciously *do* differently. In my study, bodily participation in the research process combined with bodily participation in health practices. Ultimately, this helps explain *how* and *why* photovoice altered young people's embodied *habitus*. Certain features of photovoice make it a particularly effective method for encouraging unconscious doing namely, the heightened and repeated emphasis on imitation and mimesis, the fact it was emotionally and sensorally engaged *bodies* and the emphasis on inter-subjective, as opposed to individual, doing. Each of these features will be discussed in turn below.

### ***11.5.2 Imitation, mimesis and the making of mimetic objects***

As described throughout this chapter, enacting and imitating were crucial features of young people's bodily participation and bodily learning in this project. Central to this, is the importance of mimesis and mimetic learning in practice acquisition and change. As Benjamin (1993/1999) articulates:

'Nature produces similarities; one need only think of mimicry. The highest capacity for producing similarities, however, is man's. His gift for seeing similarity is nothing but a rudiment of the once powerful compulsion to become similar and to behave mimetically. There is perhaps not a single one of his higher functions in which his mimetic faculty does not play a decisive role'

(Ibid.: 720)

The 'mimetic faculty' that Benjamin refers to a human inclination to mimic or to imitate and is crucial to the development of humans – it is something babies do all the time (as well as many other animals). Mimesis isn't just the way in which we learn practice but also in the way we transmit meanings, culture, language etc. Rather than simply being a mental process, researchers suggest that babies have an inbuilt drive to act like others (Meltzoff 1996) that doesn't require specific cognitive recognition of what they are doing and what it means. This suggests that humans learn practice largely reflexively and unconsciously and that mimesis is an innate *bodily* function. In this project, young people used their bodies to mimic, first my practices; and then each other's, in order to learn how to use cameras and then make and then use pictures in various ways. As

described above, the requirement to make pictures of health-related practices meant photovoice encouraged young people to use their bodies to repeatedly enact and mimic these practices and in doing so, bodily learn how to do them.

Bodily mimesis is important in terms of providing an explanation of how young people participated in *kinaesthetic learning* in this project but it is also particularly relevant to photovoice because it is heightened in production of mimetic objects - photographs. A mimetic object is something that resembles or mimics something else but can be essentially the same or different from an original. As described above, although photography produces objects which are materially different from their original, a visual bias, leads us to elevate the mimetic ability of photographs. They seem 'so real' to us that we commonly conceive of them as being 'copies' of reality, ignore the fact they are substantially different from that that they depict and laud their truth telling ability. As described above, much of the existing literature on photovoice follows Freire in conceiving of photographs as part of a category of visualisations which act as a 'kind of 'code'; that 'reflect the community back upon itself, mirroring the everyday social and political realities that influence people's lives' (Wang and Burris 1994: 172). This promotes meaning-centred approaches in which participants and researchers embark upon a process of 'de-coding' or unveiling the reality or truths depicted in the image.

When our perception of the boundary between copy and original dissolves to such an extent as it does with photography, mimetic objects like photographs have the potential to become, not just copies, but *simulacra* – objects that have the form or appearance of a certain thing, without possessing its substance or proper qualities (Iskander 2006). In this way, photographs, are false mimetic objects. As Gibson (1979) explains:

'[W]e have been misled for too long by the fallacy that a picture is similar to what it depicts, a likeness or an imitation of it. A picture supplies some of the information for what it depicts, but that does not imply that it is in projective correspondence with what it depicts... What it records, registers, or consolidates is information, not sense data.'

(ibid.: 279-180)

Gibson's (1979) remarks have implications for the way in which we understand what kinds of mimetic objects photographs are and what their ability is in transforming

practice. While it is largely accepted that the painting can never be an exact copy of its environment, we do not attribute the same scepticism to the photograph. As Gell (1992) explains, this is probably because of the vagueness surrounding the technology as we believe the copying process to be an inevitable consequence (being something of a natural order, not human order) and therefore believe it to be very much possible. As Gibson (1979) explains however; 'a picture is not like perceiving. Nevertheless a picture is somehow *more* like perceiving an object, place or person than is a verbal description' (ibid.: 280). Consequently, the transference of some visual information, which happens in the construction of the photographic image, fools us into believing that it is a somehow a 'truthful' or 'accurate' 'representation' of an underlying reality. As one participant articulated clearly, photographs are a compelling way to influence people because they 'help to prove the reality- they provide an example'.

This kind of thinking is grounded in objectivism and positivism and propagated by a visual bias. It concentrates on what photographs *mean* and obscures what simulacra like photographs *do*. Their importance lies, not in understanding their meaning, but in understanding the practice of their making. The practice of making images is a bodily process that includes the practice of perceiving them. Photographs do not just encapsulate meanings but inscribe practice. They are not a copy of reality but agents in constructing reality. In making images, we construct, not copy, reality. Taussig (1993) reinvigorates Fraser's (1980) notion of sympathetic magic to suggest the relationship between copy and original are so intertwined that they make 'magical mimesis' possible.

Here, young people created simulacra of themselves, both being *in* the action of the research process and *in* their health realities and in doing so, contributed to the unconscious but very active making of their lives. Understanding mimetic photographs as simulacra and not copies diverts attention from trying to understand the underlying 'truth' that they convey and towards appreciating them as new, material objects that *do* (Gell 1998) and even *want* (Mitchell 2005). This provides an explanation for how and why photovoice is able to facilitate increased participation as it relies on constant copying and mimesis. Here, the nexus of change is not thinking but doing.

## 11.6 Taking fun seriously

One of the most predominant words used by young people to describe photovoice and their participation in it was that it was '*masaya*' or made them feel '*masaya*' – a Tagalog word that interchangeably means fun and happy. As described in chapter 9, I added 'having fun' to the list of rules that participants and I drew up for the project as this something I felt strongly should be a feature of our research. My translator and co-facilitator was also keen to make session as fun as possible. In fact, he suggested this was the reason behind his success as a pastor in the local community. He was proud that he was able to built rapport with people so easily and suggested this was mainly due to his humour. Participants really took to the fun he injected into sessions and one even remarked that this was the best aspect of the project for him:

'I like Pastor Ramil – he is funny and makes us very happy here'.

*Garry, male participant*

Before I embarked on fieldwork, a lecture by Hampshire (2012) questioned why a detailed description of fun is left out of much research that purports to be so and stressed the need to be more focussed on and critically reflexive about fun in research. Fun is certainly mentioned in many studies about photovoice and more generally in participatory research. This is especially in relation to work that is done with young people. For example, Fournier et al., (2014) report how 'the use of cameras was a child-friendly and participatory experience for the children who were visibly engaged and enjoyed the process . . .[producing] a relaxed, fun atmosphere' (ibid.: 7). Moletsane et al., (2007) go further by directly acknowledging the 'large and significant element of 'having fun'' (ibid.: 21) in photovoice and report that it provided youth with a fun experience that ultimately allowed them to engage in the serious issue of HIV and AIDS, take action and have an enhanced sense of agency and self-efficacy. Although frequently mentioned, and sometimes strongly emphasized, as in the case of Moletsane et al., (2007), fun is often described as if it were a universal, taken-for-granted phenomenon. It is rarely theorized or analysed as an anthropological concept. So what is fun? Do we need to and can we operationalise this fuzzy term? Does it matter that photovoice is fun?



In terms of what fun is, we probably all have some sense of what it personally means to us. When used as a noun, fun describes something that elicits various emotions like happiness, enjoyment or amusement. Fun then, is a constellation of feelings, of experience. We do not just think fun, but *feel* it. Feelings and emotions are not simply functions of thought but rather are our 'thoughts embodied' (Rosaldo 1984: 138). In Rosaldo's (1984) work with the Ilongot of the Philippines, she defined emotion as:

'thoughts somehow 'felt' in flushes, pulses, 'movements' of our livers, minds, hearts stomachs, skin. They are *embodied* thoughts; thoughts seeped with the apprehension that "I am involved".... Emotions are about the ways in which the social world is one in which *we* are involved.

(ibid.: 143)

How then do we operationalise fun? What are the indicators of this nebulous term and can they be applied cross-culturally? First, if fun is a bodily experience, it seems logical to look for bodily expressions of fun. Again, the photographs produced in photovoice, provide a perfect basis for this. Smiling and laughing are commonly thought of as bodily ways of both expressing and creating emotions associated with fun like happiness and amusement. Many of the images from photovoice sessions (see Figure 11.15) capture young people smiling or laughing in the moments that they make, look at and use pictures, as these images reveal:

**Figure 11.15 Photographs showing participants smiling and laughing whilst using cameras and pictures. Source: author.**





Outside of the use of cameras and photographs, young people are also captured (see Figure 11.16) smiling and laughing during the act of playing games, having group discussions and in making of outputs:

**Figure 11.16 Photographs showing participants smiling and laughing during photovoice sessions. Source: author.**



As well as bodily indicators of fun, verbal expression of lived experience can also indicate the presence of fun. In evaluation interviews, the majority of participants expressed that they felt emotions like amusement, happiness and excitement, For example:

‘I enjoyed the first and second weeks when we were taking pictures. It was *masaya* (fun) . . . I was *masaya* (happy) when I am taking pictures – it’s exciting’

*Vivian, female participant*

'People are *saya* (having fun) when they look at the pictures'

*Relan, male participant*

'I particularly liked the moment when we were making a film . . . because we are making things that are *nakakatawa* (funny)'

*Ronel, male participant*

'I liked when we were showing our pictures because it was *masaya* (fun)

*Jomer, male participant*

'It made me feel *masaya* (happy) to take pictures. It is beautiful because it's nice to take pictures'

*Angelyn, female participant*

Co-facilitators too, commented on this feature of photovoice:

'Another thing I have learnt ... is that this research is very exciting. You know what, because when we are discussing the pictures everybody is excited, everybody is waking up, no one is sleeping. It is participative. It improves not only the brain but even soul. I should say soul because ... like *Ate* [term of respect] said, when she was explaining the pictures she said 'oh I am feeling nervous' so it wakes up your emotions inside'.

*Translator during photovoice training for facilitators*

'I have observed that the children are having so much fun when they are doing your project. They are always laughing and joking . . . so I know they enjoy [it]'

While these indicators may have signified fun in this context, it is important to acknowledge that fun may play out differently in different contexts and that more careful examination of indicators or expression of it are needed in order to situate the concept in locally relevant contexts. While a smile here may have indicated positive feelings, some images also reveal young people smiling in situations where they seem embarrassed or shy about presenting their thoughts. Anthropological insights suggest that the emotions conveyed in a smile are in no way universal (Nanda and Warms 2007). In this context, having fun was an obtainable and more significantly, culturally desirable thing to do. Fun, joking and laughter are a significant feature of Palawan, as well as wider Filipino culture. Jest and joking characterises much of social interaction and are important features of social bonding. Almost all meetings between people involve a period of customary joking. Here, fun may have made photovoice a 'culturally compelling strategy' (Panter-Brick, Clarke et al. 2006) but it is important to acknowledge that this may not always be the case.

Finally, it is important to consider why it matters that participating in photovoice is fun. Young people reported that photovoice was fun for many reasons as they participated in activities that they enjoyed like playing games, using new equipment, learning new skills, taking pictures, drawing, acting etc. These are features that are and can be incorporated into many participatory research strategies apart from photovoice. However, what is significant about photovoice is that it is highly sensorially captivating. As described above, making and using pictures requires bodily engagement of all of the senses including that of emotion and photographs specifically present a rather unique method for achieving such engagement. Rather than simply being an outcome of the research process or an important way to hold young people's engagement in the process (Moletsane, de Lange et al. 2007), bodily participation that is fun could be a significant factor in explaining how and why photovoice brings about change. The idea of fun being transformative has been taken far enough by some outside of classic academia, to suggest that it can bring about changes in practice. For example, a few years ago, Volkswagen's advertising agency DDB Stockholm launched a new viral campaign that sought to try and influence every-day practice by injecting fun into 'desirable' behaviours. For example, they reported that 66% more people were more

likely to use subway stairs that had been turned into a giant piano (Volkswagen 2009). More research would be needed to get a clearer sense of what fun is, how it plays out in different contexts and what affect it can have on potentially affecting people's practice.

### **11.7 Group participation**

As well as being fun, bodily participation in photovoice is also characterised by being a group, as opposed to individual, process. As described in the previous chapter, 'being together' was another sentiment that young people expressed as being a positive feature and outcome of their involvement in the project. This is particularly significant in Palawan culture where, as described elsewhere, being together is socially desirable and is linked to happiness, success and harmony.

The existing literature on photovoice emphasises the importance of groups but does so for the significance this has in helping people achieve empowerment, defined as control over decisions about their lives on an individual, organisational and community level. Above, I have presented how photovoice relied on bodily functions like enactment and imitation being carried out in an iterative cycle and suggest that photovoice encourages bodily ways of knowing and hence bodily empowerment. A key feature of this is that it is a group, not individual phenomenon. The ability to mimic relies on a conception and awareness of the self and the other but also requires a fluidity between the two so that information can be transmitted between the self or several selves to one or several others. This suggests that inter-subjectivity is important for acquiring and maintaining practices. One of the strengths of photovoice is that it relied on groups being formed who then participated in various actions together. In doing so, it creates collections of not just thinking, but participating beings.

### **11.8 Conclusion**

The current literature on photovoice follows seminal works by Wang et al. and suggests that it empowers participants to participate in decision-making that affects their lives (Wang and Burris 1994; Wang, Yi et al. 1998; Wang, Yi et al. 1998; Wang 1999). Defining empowerment as the increased ability to participate in cognitive functions like making decisions and taking control suggests that it is predominately mental process. It also suggests that practice and attempts to change practice are similarly dependent on cognitive reckoning and determination. I have challenged these assumptions and

demonstrated how thinking of empowerment as the increased ability to participate in the *bodily* act of taking part could point to other mechanisms that may facilitate young people to change their health-related practice. Rather than suggesting that photovoice should be necessarily scaled-up and used as an intervention in all health-related practice studies, these findings can be extrapolated to other methods and tell us something more general about how humans acquire and change knowledge and practice. In turn, these findings have implications for other studies that aim to change practice through engaging participants.

## Chapter 12: Discussion

I began this thesis with three interrelated aims. The first was to explore what malaria *is* in a low transmission setting. The second was to focus on young people more specifically in order to show how and why their identity is constructed. The third was to explore how and why doing photovoice could be used to engage young people in health and potentially alter their malaria-related health practices.

In trying to address these aims, a number of issues have arisen that require further elaboration in this final discussion. The first concerns the implications of there being multiple malarias that are enacted through situated, interrelational and embodied practice; the second, the significance of the similarly contingent and relational way in which young people's identity is enacted; and the third, the implications of photovoice's potential ability to 'bodily' empower young people to alter their practice. In this final chapter, I provide a discussion of each of these issues as well a discussion regarding the implications that these findings have in relation to wider attempts to understand health-related practice and potentially alter it. I also offer some suggestions of additional research that could help further develop and refine some of these ideas.

### 12.1 How and why do people *do* multiple malarias?

In this thesis, I have demonstrated how multiple malarias are enacted by various people, in different domains for various strategic purposes. Central to understanding how these different modalities emerge, is the emphasis I have put on practice. Through examining what people *do* in particular situations and under particular circumstances, it is possible to capture both 'the emergent and contingent properties of people's activities' (Cohn 2014: 157) as well as the instrumental role that practice has in enacting reality.

While I have followed Mol (2002) in describing *how* various actors coordinate their practices in such a way that makes multiple malarias somehow 'hang together' (ibid.: 55), I have also developed her work, by applying the theories of Bourdieu (1977) to explain *why* the practices of multiple actors potentially coordinate. In his work, Bourdieu poses the question of how human practice is regulated 'without being the product of obedience to some external structure, such as income or cultural norms, or to

some subjective, conscious intention, such as rational calculation' (Swartz 2002: 615). According to his theory, from childhood, individuals acquire a deeply internalised know-how and competence about the social world which is both mental and corporeal (ibid.). This *habitus* is acquired informally through 'imitation, repetition, role-play, and game participation' (ibid.: 635). Bourdieu (1991) refers to '*habitus*' as a system of 'structuring structures' which suggests that there is not only an *inherited* quality to it but also an *innovative* one too (Swartz 2002). Although dispositions become internalised, they do not *determine* action, but *shape* and *orientate* it as actors are afforded agency in generating new forms of action, based on the their socialisation experiences (ibid). It is this innovative quality of *habitus* that is important for this discussion as Bourdieu (1997) suggests that actors deploy agency in regulating their practice through the development of certain 'strategies' and 'interests' (ibid.) within certain social fields. Significantly, these strategies are not necessarily conscious, deliberate intentions by the author but emerge in the moment in relation to 'systems of objective potentialities, immediately inscribed in the present, things to do or not to do, to say or not to say, in relation to a *forthcoming* reality (ibid.: 76).

In this thesis, I have shown how the practices of various groups in this setting, although sometimes heterogeneous, are coordinated and suggest that this could be precisely because of their shared strategies or interests as opposed to just their shared knowledge. For example, the malarias of governance are uniformly a top 'priority' that are thought of and enacted as though they can be overcome and eventually 'eliminated' as well as 'taught' and 'educated'. These malarias help health professionals to achieve some of their politically and economically motivated goals within highly politicised contexts. These exist in relation to the malarias of healers who treat malaria in Bataraza. These malarias of professionalization; although multiple are all objectified and 'hidden' inside bodies requiring expertise to ideally uncover or see them; and require the use of specialised instruments to both uncover and treat them. These exist in relation to the malarias that are *done* by patients alongside their strategic aim of 'feeling better' and maintaining wellness. These malarias are neither always predictable nor linear and often involve 'straddling' (McMillen 2004; Hampshire and Owusu 2013) multiple systems; can be characterised by features like ambivalence and fatalism which, counter-intuitively perhaps, facilitate, rather than inhibit action; and are often a communal issue



between families and community members that do not always require the consultation of professionals.

Despite the heterogeneity that exists, people in Bataraza are united in wanting to take steps to alleviate malarias. On a global scale too, malaria continues to be a major public health concern for the international community with huge amounts of effort and investment directed at trying to control it. The latest malaria report from the World Health Organisation (2013) estimated that there were about 207 million cases of malaria in 2012 (with an uncertainty range of 135 million to 287 million) and an estimated 627 000 deaths (with an uncertainty range of 473 000 to 789 000) (ibid.). While the international donor community continues to invest billions of dollars into malaria control and elimination, 'in an austere era, sustaining momentum . . . requires that limited financial resources are deployed with maximum efficiency' (Pigott, Atun et al. 2012: 2). Years of work on malaria have yielded many lessons and there is increased recognition that local settings matter in terms of guiding how malaria is tackled across the world. The public health community routinely acknowledge that there is no 'silver bullet', no single strategy that can resolve malaria and stress the need for different 'combinations' of 'tools' to be applied in different settings. However, mere recognition of the complexity of the solutions need to tackle malaria in local contexts is not the same as appreciating the multiplicity of the disease *itself* and the recognition that malaria does not merely manifest in different forms in different settings, but actually *exists* in different forms.

As such, these multiple malarias require equally diverse responses that go beyond just technical solutions. In a recent conference at the London School of Hygiene and Tropical Medicine, social scientists working in malaria stressed the need for the international health community to 're-imagine' malaria, urging that, rather than one malaria, we talk of multiple malarias and attend not to the solutions for malaria but to 'focal' malaria themselves (Chandler, Beisel et al. 2014). Rather than just being an issue of semantics, in line with these recommendations, I suggest that in order for efforts to succeed, whether organisational or individual, the socially embedded nature of illness and the way in which it is situationally, relationally and unconsciously enacted through practice needs to be taken more into account so that broader versions of malaria are not neglected (Kelly and Beisel 2011). As well as helping to better understand the complex

phenomenon that we are dealing with, the shift in focus to how multiples malarias are enacted through practice will also help with the development of broader solutions which directly operate at and therefore interact with this level of practice. As I go on to describe, photovoice presents one possible way in which *enacted* malarias can both be revealed *and* potentially altered.

## **12.2 How and why are young people's identities enacted?**

As well as trying to understand the nature of malaria-related practice more generally, I have also emphasised the importance in understanding the way in which young people's identity is constructed as this has implications for the role that they can have in promoting their own health as well as that of their families. This builds on recent literature that suggests that young people are active health-seekers and health-promoting agents in their own right (Geissler, Nokes et al. 2000) and responds directly to the call for research to begin with children's medical realities (Hampshire, Porter et al. 2011). I have built on this literature by theorising how identity is enacted through practice and explored why this impacts young people's role as health agents.

By beginning with the lived experience and practices of young people within the Palawan setting, I have emphasised the contingent nature of their identities which they enact through relationships in various settings. I have described how, according to young people, they enact their lives and interactions within three major domains or 'fields' (Bourdieu 1977): the family unit, the marriage unit and school. Within these domains, young people engage in the processual act of building, maintaining and deconstructing various kinds of important relationships with others across time and space which shapes both the 'self' and what the self does.

Multiple authors have investigated cross-cultural variations in the notion of the 'self' and person. Notably, Dumont (1980) distinguished between hierarchical persons that characterise systems based on 'holism' in India and egalitarian persons that characterise systems based on 'individualism' in the 'West' (Robbins 2002). Building on Dumont, a number of scholars have pointed out how the individualism (whereby the individual is the paramount cultural value (Robbins 2002) found in Anglo-America contexts is absent or problematic when carried across into other settings. They suggest instead that 'dividualism' might be a more appropriate conception of personhood in

these contexts (eg. Strathern 1998). Under the umbrella of ‘dividuals’ it is possible to find a range of situations including ‘relationalism’ (Robbins 2002) and ‘groupism’ (Sugimoto 2013 cited in Smith 2012) that lead to the creation of persons who are essentially ‘porous’ (Smith 2012) in nature. Here, I have shown how Palawan culture is characterised by a sense of the ‘self’ that aligns more with the broad concept of a ‘dividual’ as opposed to a ‘individual’ in that identity is largely relationally and collectively defined and that these notions are paramount cultural values.

This is most clearly demonstrated when looking at processes that lead to decisions being made. In this thesis, I have shown how ‘dividual’ health decisions are made by subjects in relation to others, not by objects in isolation. Following Sariola and Simpson, (2011) it is useful to think of these ‘dividuals’ as ‘heteronomous’, as opposed to autonomous. The practice of decision-making, like all practice is grounded in the wider social and cultural context in which it is situated and not easily isolated or measurable, separate from these contexts. Palawan young people are bound in multiple networks of relationships that shape their identity and these networks have a profound effect on who they are at various times and in various spaces. In turn, this affects what they do in these situations including in relation to health. A young male like Dowit who was described in chapter 8, trying to assert his superiority over his younger sister may insist that she asks his permission before taking medicines but he will defer to his older parents and siblings when he wishes to take medicine himself in order to preserve his inferior social status in relation to them. As such, I have shown how commonly used indicators of individual practice like self-esteem and self-efficacy that are grounded in universalising notions of the ‘self’ are, as a result, problematic when applied to different settings where the ‘self’ exists in very different modalities.

In this thesis, I have argued that the mere recognition that the concept of the ‘individual’ is not necessarily universally applicable, reveals that by extension, the health practice of ‘dividuals’ is equally contingent and requires situating *within* local contexts as it is carried out by the embodied practice of local ‘selves’. This links with the recognition that multiple malarias are enacted through the practices of various ‘dividuals’ and suggests there is an intimate link between how and why disease is *done* and the identity of those who enact it. Efforts aimed at altering practice must therefore take account of and attend to this situated, relational and embodied nature of enacted identity.

### 12.3 How and why does photovoice illuminate and alter practice?

The final area that requires further discussion here is how and why the method photovoice can both illuminate and alter how malaria is *done* and what the implications are for other efforts to alter health-related practices. As a research method, I have shown how photovoice does not neutrally enter into any context as a means to ‘uncover’ reality, as is often implied in many current research studies. As researchers, it is important to document the settings in which research is conducted in greater detail than is currently done in order to acknowledge the contextually specific nature of both the lived experience of practice that is *depicted* and potentially *altered* through methods like photovoice as well as the anthropological knowledge generated about it.

It is precisely the power of photographs and the process of making them to *enact* and not just *reflect* reality, that make a method based on this technology, a compelling way to also potentially transform practice. In this thesis, I have shown how, as a result of engaging in the process of making and sharing photographs, young people were able to potentially catalyse personal and community change in a number of ways. In particular, they: enabled young people to learn new things; make friends and be together; feel less shy and more able to teach others what they had learnt; and help alter their own and their families’ malaria-related health practices. Crucially, photovoice seemed to change young people’s role in promoting health *in relation* to others.

The important question then becomes *how* photovoice brought about these changes and what this can tell us about health-related practice, identity and ‘behaviour’ change more generally. In this thesis, I have developed the existing literature on photovoice further and offered an alternative explanation of how this method potentially catalyses personal and community change. Contrary to existing literature that focuses on cognitive aspects of participation and empowerment, I suggest that photovoice requires people to *bodily do*, not just *cognitively think*, in both the research process and in their own health-related practices. Building on Bourdieu’s (1977) notion of ‘*habitus*’, I argue that photovoice encourages bodily participation because it builds on what Benjamin (1993/1999) calls our ‘mimetic faculty’ causing participants to engage in an unconscious, but potentially transformative, process of copying, copy-making and mimetic learning. Furthermore, photovoice engages all our bodily senses, eliciting emotions which make it fun which makes it a wholly ‘engaging’ process. Bodily

participation in photovoice is also potentially transformative because it is an inter-subjective process that occurs in groups, not just an individual level. In doing so, photovoice creates collections of participating beings. By re-thinking participation in the photovoice process, I provide an alternative explanation for how it, as a method, can potentially 'bodily empower' people to affect their every-day practice.

The philosophy of embodiment stresses the integration of the mind and body in the human subject. We are at once thinking and feeling beings. This extends to all aspects of our experience including the creation of our identity and the practices that we engage in, including those related to health. In line with this, photovoice, as a method, encourages, and possibly blurs the boundaries between, *both* bodily and mental engagement and as such, offers room for both to be altered. I have argued in this thesis that it is this crucial feature of photovoice that makes it potentially transformative. This then has implications for the way in which people can be 'empowered' to make changes in their lives, particularly in relation to health. Many conventional public health strategies are predicated on the notion that empowerment is a largely cognitive process. Consequently, they aim to change what the body does through changing what the mind thinks. The plethora of studies and interventions that focus on changing knowledge or 'empowering' people to 'think critically' and make mental 'decisions' is testament to this. The existing literature on photovoice also claims its effectiveness lies in its ability to 'empower' *individuals* to make changes to their lives by generating *critical consciousness* (Wang and Burris 1994; Wang and Burris 1997; Wang, Yi et al. 1998; Wang 1999). However, photovoice also encourages groups of bodies to both *do* and *think* in relation to each other. Crucially, the act of doing is not wholly dependent on the act of conscious thought and occurs unconsciously throughout various stages of the process. As such, this suggests that 'unconscious doing' could be the nexus for changing both what people do and think, as opposed to 'conscious thinking'. In this thesis, I therefore argue that given the central role that situated, relational and embodied practice plays in enacting diseases and the identities of those that enact practices, methods that directly operate at and therefore interact with the level of practice may be more effective strategies for initiating 'behaviour' change.

Just after finishing the initial draft of this thesis, I happened to watch a documentary called *The Act of Killing*, in which director Joshua Oppenheimer offers the audience an

insight into the Indonesian death squads who tortured and killed thousands of suspected communists in the mid-1960s. In this powerful piece of work, Oppenheimer presents a film within a film as he records what happens when he gave aging gangsters the opportunity to create a dramatised film of their own that documented their past acts of killing. The film focuses on one particular aged paramilitary, Anwar Congo. We first meet him gleeful, boastful and utterly guiltless regarding his past actions, taking real delight in cognitively re-calling his past concerning how and where he killed various victims in gruesome ways that were inspired by American gangster films. However, as the film unfolds, and Anwar engages in the act of theatrically re-enacting his past, including one particularly powerful scene in which he imitates the role of one of his victims being strangled, we see a transformation in him. It becomes clear how the very act of repetitively engaging *bodily* in the process of re-creating his past to present in a new visual format, has a profound effect on Anwar. By the end of the film, he is unable to reconcile what he has done, questioning whether he has greatly sinned. Significantly, he reveals that by acting out the role of his victims, he is now able to 'feel how they feel'. Even the extras (mainly women and children) that he hired to re-enact being attacked by the gangsters, are left crying and shaking as a result of re-creating such horrific scenes. This bodily reaction is so palpable in Anwar that the closing scene of the film shows him at his regular killing ground, totally unable to narrate his past actions as he did with so much pride and pomp at the start. Speechless and shaking, all he can do is give in to the uncontrollable, violent retching that the place, and its memories, now elicit from him. In this haunting portrayal, *The Act of Killing*, illustrates just how potentially transformative *bodily* participation can be in bringing about *bodily* empowerment. It seems unlikely that Anwar's life would have been so dramatically upturned if he had been asked solely to reflect mentally on his life through narrative and speech, as in a traditional documentary interview. Rather the necessity for him to physically act out his lived experience and even more importantly, re-enact and watch portrayals of those of his victims, led him to change not just the way he thought but also the way in which he felt and *did* as a result.

#### **12.4 Suggestions for future research**

Many ideas explored in this thesis offer potential avenues for further research. In particular, the enacted nature of malaria should be explored in many more contexts,

namely in sub-Saharan Africa where malaria burden is the highest, in order to better understand how 'behaviour' change can be better achieved in more locally relevant ways. Similarly, while the emphasis on young people in this thesis builds on a growing body of existing research, more work could be done to explore the construction of young people's identity in relation to their health-related practices in other contexts in order to facilitate more youth-orientated and/or youth-led interventions.

While photovoice was shown to be potentially effective in altering practice in this context, it would be prudent to apply the methodology in other settings in order to add to the body of data presented that suggests photovoice can successfully be used as an intervention. Here, photovoice was conducted with a relatively large number of participants and over a relatively long period of time when compared to many other studies. However, the longer-term effects of the project were only investigated 3-5 months after the intervention. It was also beyond the scope of this particular study to investigate the potential for the transfer or scale-up of photovoice in order to engage an even greater number of participants over a longer period of time. Crucially, it would be useful to investigate the potential of participants themselves to transfer or scale-up photovoice by teaching others about the process and thereby conduct community-led (and particularly youth-led) action. Here, the structure of schools and commitment of teachers were important in ensuring the success of this project. However, given some of the disadvantages and limitations explored in this thesis, it would be useful to carry out further photovoice projects with young people outside of the school context (including both school-going and non school-going youth) or using alternative facilitators.

Finally, this thesis offered a critique to the current literature on photovoice and suggested a potentially alternative route to altering practice based on *bodily* empowerment. However, future work is needed to explore this idea further by investigating the impact of a range of methods (including photovoice) that potentially operate at and interact with the level of practice. This would make an additional theoretical contribution to existing research relating to behaviour and behaviour change.

## Appendix one

### Appendix one: Questionnaire for Young People – English Translation

Today's date

[ ][ ] \ [ ][ ] \ [ ][ ]

#### Part I: General Information

**1. Name**

.....  
(first name), (middle name), (second name)

**2. Name of parent/adult in the project**

.....  
(first name), (middle name), (second name)

**3. Village**

.....

**4. Age**

**IF NOT SURE RECORD AS 99**

[ ][ ]

**5. How many brothers and sisters older than you live in your house?**

[ ][ ]

**6. How many brothers and sisters younger than you live in your house?**

[ ][ ]

**7. Sex**

- 1) Male [ ]  
2) Female [ ]

**8. Are you married or not?**

- 1) Married [ ]  
2) Single [ ]  
3) Widowed [ ]  
4) Divorced [ ]  
5) Other .....[ ]

**9. Religion**

- 1) Native/Palawano [ ]  
2) Islam [ ]  
3) Christian [ ]  
4) Other .....[ ]  
5) No religion [ ]

**10. Ethnic group**

- 1) Palawano [ ]



2) Other ..... ☐

**11. Education level reached?**

- 1) Grade 1-3 ☐
- 2) Grade 4 ☐
- 3) Grade 5 ☐
- 4) Grade 6 ☐
- 5) Grade 7 ☐
- 6) High school ☐
- 7) No education ☐
- 8) Other..... ☐

**12) Work or occupation?**

**TICK MORE THAN ONE IF NECESSARY**

- 1) Student ☐
- 2) Farmer ☐
- 3) Casual worker ☐
- 4) No occupation ☐
- 5) House wife/husband ☐
- 6) Other..... ☐

**13) How many children do you have?**

☐☐

**14) What do you think are the three main illnesses that affect young people [aged 10-19] in your village?**

**RANK 1-3 IN ORDER MENTIONED**

- 1) Malaria ☐
- 2) Fever ☐
- 3) Cholera ☐
- 4) Vomiting ☐
- 5) Diarrhoea ☐
- 6) Diarrhoea and vomiting ☐
- 7) Headache ☐
- 8) Typhoid ☐
- 9) UTI ☐
- 10) Coughing/flu ☐
- 11) Spirits ☐
- 12) None ☐
- 13) Other..... ☐

**15) What do you think are the three main illnesses that affect adults in your village?**

**RANK 1-3 IN ORDER MENTIONED**

- 1) Malaria ☐
- 2) Fever ☐
- 3) Cholera ☐
- 4) Vomiting ☐
- 5) Diarrhoea ☐
- 6) Diarrhoea and vomiting ☐
- 7) Headache ☐
- 8) Typhoid ☐
- 9) UTI ☐
- 10) Coughing/flu ☐
- 11) Spirits ☐
- 12) None ☐
- 13) Other..... ☐

## Part 2: Fever

**1. Do you agree with this statement? Fever is a problem in my village.**

- 1) Yes ☐ 2) maybe ☐ 3) No ☐ 4) no opinion ☐

**2. Do you agree with this statement? Fever is a dangerous illness.**

- 1) Yes ☐ 2) maybe ☐ 3) No ☐ 4) no opinion ☐

**3. How far do you agree that each of the following can cause a person to have fever?**

### READ LIST

**1= really yes, 2=maybe yes, 3=Neutral, 4=maybe no 5=definitely no**

- 1) Change in climate ☐
- 2) Working too much without rest /fatigue ☐
- 3) Hunger ☐
- 4) Dirty food ☐
- 5) Coconut juice ☐
- 6) Dirty water ☐
- 7) Dirty surroundings ☐
- 8) Mosquitoes ☐
- 9) Typhoid ☐
- 10) Malaria ☐
- 11) UTI ☐
- 12) Vomiting ☐
- 13) Diarrhoea ☐
- 14) Diarrhoea and vomiting ☐
- 15) Flu ☐
- 16) Spirits ☐

**4. If you became sick with fever which of the following would you do first?**

### READ LIST AND TICK ONE ANSWER

- 1) Go to the Barangay Health Centre ☐
- 2) Go the Rural Health Unit ☐
- 3) Go to the Barangay Health Worker ☐
- 4) Go to the hospital ☐
- 5) Go to the traditional healer (arbularyo/baylan/tongkol/hilot) ☐
- 6) Take herbal medicine (halamang ugat) ☐
- 7) Cool the body with towels (maglagay ng basing tela sa katawan) ☐
- 8) Take paracetamol/biogesic ☐
- 9) Take an anti-malarial ☐
- 10) Take Bioflu/Neozep ☐
- 11) Other ..... ☐
- 12) Nothing ☐
- 13) Tell an adult (pinaalam sa magulang) ☐

**IF 1-4 GO TO QUESTION 5**

**IF 5 GO TO QUESTION 9**

**IF 6-11 GO TO QUESTION 12**

**If 12-13 GO TO QUESTION 17**

**5. How many hours or days would you wait from having fever before you did that?**

**IF THE SAME DAY RECORD AS 00**

**IF NOT SURE RECORD AS 99**

[\_][\_]

**6. Would you do that alone?**

- 1) Yes [\_]
- 2) No [\_] who with?.....
- 3) Maybe [\_]

**7. Would you do any of the following things before going to the BHS/RHU/Hospital/BHW?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Tell an adult (pinaalam sa magulang) [\_]
- 2) Take paracetamol/biogesic [\_]
- 3) Take anti-malarial [\_]
- 4) Take Bioflu/ Neozep [\_]
- 5) Go to the Traditional healer (arbularyo/baylan/tongkol/hilot)[\_]
- 6) Take herbal medicine (halamang ugat) [\_]
- 7) Cool the body with towels (maglagay ng basing tela sa katawan) [\_]
- 8) Other..... [\_]

**8. If you went to the BHS/RHU/Hospital/BHW with fever would you expect them to do any of following?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Give you a check up [\_]
- 2) Give you a smear test for malaria [\_]
- 3) Give paracetamol/biogesic [\_]
- 4) Give an anti-malarial [\_]
- 5) Other..... [\_]

**NOW GO TO QUESTION 14**

**9. How many hours or days would you wait from having fever before you did that?**

**IF THE SAME DAY RECORD AS 00**

**IF NOT SURE RECORD AS 99**

[\_][\_]

**10. Would you do that alone?**

- 1) Yes [\_]
- 2) No [\_] who with?.....
- 3) Maybe [\_]

**11. Would you do any of the following things before going to arbularyos/balayan/tonkol/hilot?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Tell an adult (pinaalam sa magulang) [\_]
- 2) Take paracetamol/biogesic [\_]
- 3) Take anti-malarial [\_]

- 4) Take Bioflu/Neozep ☐
- 5) Take herbal medicine (halamang ugat) ☐
- 6) Cool the body with towels/steaming (maglagay ng basing tela sa katawan) ☐
- 7) Go to the Barangay Health Centre ☐
- 8) Go the Rural Health Unit ☐
- 9) Go to the Barangay Health Worker ☐
- 10) Go to the hospital ☐
- 11) Other.....☐

**NOW GO TO QUESTION 14**

**12. How many hours or days would you wait from having fever before you did that?**

**IF THE SAME DAY RECORD AS 00**

**IF NOT SURE RECORD AS 99**

☐☐

**13. Would you do that alone?**

- 1) Yes ☐
- 2) No ☐ who with?.....
- 3) Maybe ☐

**NOW GO TO QUESTION 14**

**14. After the first action, how long would you wait to see if there was a result?**

**TICK ONE ANSWER**

- 1) Less than 30 minutes ☐
- 2) 30 minutes to 1 hour ☐
- 3) More than 1 hour on same day ☐
- 4) Next day ☐
- 5) 3-7 days ☐
- 6) Over 7 days ☐
- 7) Other..... ☐

**15. If you still did not get better, what would you do next?**

**READ LIST AND TICK ONE ANSWER**

- 1) Go to the Barangay Health Centre ☐
- 2) Go to the Barangay Health Worker ☐
- 3) Go the Rural Health Unit ☐
- 4) Go to the hospital ☐
- 5) Go to the Traditional healer (arbularyo/balyan/tongkol/hilot) ☐
- 6) Take herbal medicine (halamang ugat) ☐
- 7) Cool the body with towels/steaming (maglagay ng basing tela sa katawan) ☐
- 8) Nothing ☐
- 9) Tell an adult (pinaalam sa magulang) ☐
- 10) Take paracetamol/biogesic ☐
- 11) Take anti-malarial ☐
- 12) Take Bioflu/Neozep ☐
- 13) Other..... ☐

**16. Would you do that alone?**

- 1) Yes ☐
- 2) No ☐ who with?.....
- 3) Maybe ☐

**NOW GO TO QUESTION 17**

**17. Have you had fever in the last 30 days?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**IF 1 GO TO QUESTION 18**

**IF 2 OR 3 GO TO PART 3: MEDICINES FOR FEVER**

**18. The last time you had fever, which of the following signs did you have?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Headache (sakit ng ulo) ☐
- 2) High temperature/fever (lagnat) ☐
- 3) Chilling (panginginig) ☐
- 4) Body pain (sakit ng katawan) ☐
- 5) Sweating (pag pawis) ☐
- 6) Loss of appetite (walang gana kumain) ☐
- 7) Loss of energy/feeling tired (panghihina) ☐
- 8) Dizziness (nahihilo) ☐
- 9) Coughing/flu (pag ubo/sipon) ☐
- 10) Vomiting (pag susuka) ☐
- 11) Diarrhoea (pag tatae) ☐
- 12) Diarrhoea and vomiting (suka tae) ☐

**19. The last time you got fever what is the first thing you did?**

**READ LIST AND TICK ONE ANSWER**

- 1) Go to the Barangay Health Centre ☐
- 2) Go the Rural Health Unit ☐
- 3) Go to the Barangay Health Worker ☐
- 4) Go to the hospital ☐
- 5) Go to the traditional healer (arbularyo/baylan/tongkol/hilot) ☐
- 6) Take herbal medicine (halamang ugat) ☐
- 7) Cool the body with towels (maglagay ng basing tela sa katawan) ☐
- 8) Take paracetamol/biogesic ☐
- 9) Take an anti-malarial ☐
- 10) Take Bioflu/Neozep ☐
- 11) Other.....☐
- 12) Nothing ☐
- 13) Tell an adult (pinaalam sa magulang) ☐

**IF 1-5 GO TO QUESTION 20**

**IF 6 GO TO QUESTION 25**

**IF 7-11 GO TO QUESTION 29**

**IF 12- 13 GO TO PART 3: MEDICINES FOR FEVER**

**20. How many hours or days did you wait before you that when you had fever?**

**IF THE SAME DAY RECORD AS 00**

**IF NOT SURE RECORD AS 99**

[\_][\_]

**21. Did you do that alone?**

- 1) Yes [\_]
- 2) No [\_] who with?.....
- 3) Maybe [\_]

**22. The last time you had fever did you do any of the following things before going to the BHS/RHU/Hospital/BHW?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Tell an adult (pinaalam sa magulang) [\_]
- 2) Take paracetamol/biogesic [\_]
- 3) Take anti-malarial [\_]
- 4) Take Bioflu/Neozep [\_]
- 5) Go to the Traditional healer (arbularyo/balyan/tongkol/hilot) [\_]
- 6) Take herbal medicine (halamang ugat) [\_]
- 7) Cool the body with towels/steaming (maglagay ng basing tela sa katawan) [\_]
- 8) Anything else?..... [\_]

**23. When you went to the BHS/RHU/Hospital/BHW did they do any of following?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Give you a check up [\_]
- 2) Give you a smear test for malaria [\_]
- 3) Give paracetamol/biogesic [\_]
- 4) Give an anti-malarial [\_]
- 5) Other..... [\_]

**24. Was the treatment given by the BHS/RHU/Hospital/BHW effective?**

- 1) Yes [\_]
- 2) No [\_]
- 3) Not sure [\_]

**IF 2 GO TO QUESTION 32**

**IF 1 OR 3 GO TO PART 3: MEDICINES FOR FEVER**

**25. How many hours or days did you wait before you that when you had fever?**

**IF THE SAME DAY RECORD AS 00**

**IF NOT SURE RECORD AS 99**

[\_][\_]

**26. Did you do that alone?**

- 1) Yes ☐
- 2) No ☐ who with?.....
- 3) Maybe ☐

**27. The last time you had fever did you do any of the following things before going to arbularyos/balayan/tonkol/hilot?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Tell an adult (pinaalam sa magulang) ☐
- 2) Take paracetamol/biogesic ☐
- 3) Take anti-malarial ☐
- 4) Take Bioflu/Neozep ☐
- 5) Take herbal medicine (halamang ugat) ☐
- 6) Cool the body with towels/steaming (maglagay ng basing tela sa katawan) ☐
- 7) Go to the Barangay Health Centre ☐
- 8) Go the Rural Health Unit ☐
- 9) Go to the Barangay Health Worker ☐
- 10) Go to the hospital ☐
- 11) Anything else?.....☐

**28. Was the treatment given by the arbularyos/balayan/tonkol/hilot effective?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**IF 2 GO TO QUESTION 32**

**IF 1 OR 3 GO TO PART 3: MEDICINES FOR FEVER**

**29. How many hours or days did you wait before you that when you had fever?**

**IF THE SAME DAY RECORD AS 00**

**IF NOT SURE RECORD AS 99**

**30. Did you do that alone?**

- 1) Yes ☐
- 2) No ☐ who with?.....
- 3) Maybe ☐

**31. Was the treatment effective?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**IF 2 GO TO QUESTION 32**

**IF 1 OR 3 GO TO PART 3: MEDICINES FOR FEVER**

**32. After the first action, how long did you wait to see if there was a result?**

**TICK ONE ANSWER**

- 1) Less than 30 minutes ☐
- 2) 30 minutes to 1 hour ☐
- 3) More than 1 hour on same day ☐
- 4) Next day ☐
- 5) 3-7 days ☐
- 6) Over 7 days ☐
- 7) Other..... ☐

**33. After the first treatment was not effective, which one of the following did you do next?**

**READ LIST AND TICK ONE ANSWER**

- 1) Go to the Barangay Health Centre ☐
- 2) Go to the Barangay Health Worker ☐
- 3) Go the Rural Health Unit ☐
- 4) Go to the hospital ☐
- 5) Go to the Traditional healer (arbularyo/balyan/tongkol/hilot) ☐
- 6) Take herbal medicine (halamang ugat) ☐
- 7) Cool the body with towels/steaming (maglagay ng basing tela sa katawan) ☐
- 8) Nothing ☐
- 9) Tell an adult (pinaalam sa magulang) ☐
- 10) Take paracetamol/biogesic ☐
- 11) Take anti-malarial ☐
- 12) Take Bioflu/Neozep ☐
- 13) Other..... ☐

**34. Did you do that alone?**

- 1) Yes ☐
- 2) No ☐ who with?.....
- 3) Maybe ☐

**35. Was the treatment you were given this time effective?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**NOW GO TO PART 3: MEDICINES FOR FEVER**



## Part 3: Medicines for fever

1. How many medicines for fever (excluding herbal) can you name?

[ ] [ ]

LIST MEDICINES MENTIONED

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-----  
-----  
-----  
-----  
-----

2. Have you ever bought/got medicines (excluding herbal) for fever yourself without asking an adult first?

- 1) Yes [ ]  
2) No [ ]  
3) Not sure [ ]

IF 1 GO TO QUESTION 3

IF 2 OR 3 GO TO QUESTION 4

3. Have you bought/got medicines for fever from any of the following without asking an adult first?

READ LIST

1=Yes, 2= No, 3=Not sure

- |                              |     |
|------------------------------|-----|
| 1) Friends/family/neighbours | [ ] |
| 2) Sari Sari store           | [ ] |
| 3) Market                    | [ ] |
| 4) Pharmacy                  | [ ] |
| 5) Barangay Health Worker    | [ ] |
| 6) BHS/RHU/Hospital          | [ ] |
| 7) Anywhere else?            | [ ] |

NOW GO TO QUESTION 4

4. Have you ever taken medicines (excluding herbal) for fever without asking an adult first?

- 1) Yes [ ]  
2) No [ ]  
3) Not sure [ ]

5. Have you ever given medicines (excluding herbal) for fever to any of the following without asking an adult first?

READ LIST

1=Yes, 2= No, 3=Not sure

- 1) Family members younger than you [ ]

- 2) Family members the same age as you ☐
- 3) Family members older than you ☐
- 4) Non-family members younger than you ☐
- 5) Non-family members the same age as you ☐
- 6) Non-family members older than you ☐

**6. How many herbal medicines for fever can you name?**

☐☐

**LIST MEDICINES MENTIONED**

-----

-----

-----

-----

-----

-----

**7. Have you ever bought/got herbal medicines for fever yourself without asking an adult first?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**IF 1 GO TO QUESTION 8**

**IF 2 OR 3 GO TO QUESTION 9**

**8. Have you bought/got herbal medicines for fever from any of the following without asking an adult first?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Friends/family/neighbours ☐
- 2) Sari Sari store ☐
- 3) Market ☐
- 4) Pharmacy ☐
- 5) Barangay Health Worker ☐
- 6) BHS/RHU/Hospital ☐
- 7) Anywhere else? ☐

**NOW GO TO QUESTION 9**

**9. Have you ever taken herbal medicines for fever without asking an adult first?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**10. Have you ever given herbal medicines for fever to any of the following without asking an adult first?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Family members younger than you ☐
- 2) Family members the same age as you ☐
- 3) Family members older than you ☐
- 4) Non family members younger than you ☐
- 5) Non family members the same age as you ☐
- 6) Non family members older than you ☐

**11. How far do you agree with this statement? Herbal medicine is effective for fever.**

- 1) Yes ☐ 2) Maybe ☐ 3) No ☐ 4) No opinion ☐

**12. How far do you agree with this statement? Medicine from the Rural Health Unit is effective for fever.**

- 1) Yes ☐ 2) Maybe ☐ 3) No ☐ 4) No opinion ☐

## Part 4: Malaria

### 1. Do you agree with this statement? Malaria is a problem in my village.

- 1) Yes ☐ 2) maybe ☐ 3) No ☐ 4) no opinion ☐

### 2. Do you agree with this statement? Malaria is a dangerous illness.

- 1) Yes ☐ 2) maybe ☐ 3) No ☐ 4) no opinion ☐

### 3. Where have you read or heard information about malaria?

#### READ LIST

1=Yes, 2= No, 3=Not sure

- |   |                          |
|---|--------------------------|
| 1) Radio                                  | <input type="checkbox"/> |
| 2) TV                                     | <input type="checkbox"/> |
| 3) Posters/pamphlets                      | <input type="checkbox"/> |
| 4) School                                 | <input type="checkbox"/> |
| 5) Teachers                               | <input type="checkbox"/> |
| 6) Friends/family who are adults          | <input type="checkbox"/> |
| 7) Friends/family who are young people    | <input type="checkbox"/> |
| 8) Health workers (e.g. BHS or RHU staff) | <input type="checkbox"/> |
| 9) Other .....                            | <input type="checkbox"/> |

### 4. Do you agree that each of the following can cause a person to have malaria?

1= Definitely yes, 2=maybe yes, 3=Neutral, 4=maybe no, 5=Definitely no

- |   |                          |
|---|--------------------------|
| 1) Change in climate (Init ulan init ulan)                                  | <input type="checkbox"/> |
| 2) Working too much without rest /fatigue (subrang trabaho o subrang pagod) | <input type="checkbox"/> |
| 3) Hunger (gutom)   | <input type="checkbox"/> |
| 4) Dirty food (maruming pagkain)  | <input type="checkbox"/> |
| 5) Coconut juice (sabaw ng buko)  | <input type="checkbox"/> |
| 6) Dirty water (maruming tubig)   | <input type="checkbox"/> |
| 7) Dirty surroundings (maruming kapaligiran)                                | <input type="checkbox"/> |
| 8) Mosquitoes (lamok)   | <input type="checkbox"/> |

### 5. Do you do any of the following to prevent malaria?

#### READ LIST

1=Yes, 2= No, 3=Not sure

- |   |                          |
|---|--------------------------|
| 1) Not stay out in the sun (huwag magbilad sa araw)                   | <input type="checkbox"/> |
| 2) Take rest when working (wag subrang trabaho)                       | <input type="checkbox"/> |
| 3) Clean the surroundings (linisin ang paligid)                       | <input type="checkbox"/> |
| 4) Drink clean water only (uminom ng malinis na tubig lamang)         | <input type="checkbox"/> |
| 5) Prepare food properly (ihanda ng maayos ang pagkain)               | <input type="checkbox"/> |
| 6) Spray the house (Magpa bumba ng bahay)                             | <input type="checkbox"/> |
| 7) Use a mosquito net while sleeping (gumamit ng kulambo sa pagtulog) | <input type="checkbox"/> |
| 8) Burn leaves for smoke (magpa-pausok sa paligid palagi)             | <input type="checkbox"/> |
| 9) Other .....  | <input type="checkbox"/> |

### 6. How far do you agree that each of the following are signs of malaria?

1= Definitely yes, 2=maybe yes, 3=Neutral, 4=maybe no, 5=Definitely no

- |                            |                          |
|----------------------------|--------------------------|
| 1) Headache (sakit ng ulo) | <input type="checkbox"/> |
|----------------------------|--------------------------|

- 2) High temperature/fever (lagnat) ☐
- 3) Chilling (panginginig) ☐
- 4) Body pain (sakit ng katawan) ☐
- 5) Sweating (pag pawis) ☐
- 6) Loss of appetite (walang gana kumain) ☐
- 7) Loss of energy/feeling tired (panghihina) ☐
- 8) Dizziness (nahihilo) ☐
- 9) Coughing/flu (pag ubo/sipon) ☐
- 10) Vomiting (pag susuka) ☐
- 11) Diarrhoea (pag tatae) ☐
- 12) Diarrhoea and vomiting (suka tae) ☐

**7. If you became sick with malaria which of the following would you do first?**

**TICK ONE ANSWER**

- 1) Go to the Barangay Health Centre ☐
- 2) Go the Rural Health Unit ☐
- 3) Go to the Barangay Health Worker ☐
- 4) Go to the hospital ☐
- 5) Go to the traditional healer (arbularyo/baylan/tongkol/hilot) ☐
- 6) Take herbal medicine (halamang ugat) ☐
- 7) Cool the body with towels (maglagay ng basing tela sa katawan) ☐
- 8) Take paracetamol/biogesic ☐
- 9) Take an anti-malarial ☐
- 10) Take Bioflu/Neozep ☐
- 11) Other..... ☐
- 12) Nothing ☐
- 13) Tell an adult (pinaalam sa magulang) ☐

**IF 1-4 GO TO QUESTION 8**

**IF 5 GO TO QUESTION 12**

**IF 6-11 GO TO QUESTION 15**

**If 12-13 GO TO QUESTION 20**

**8. How many hours or days would you wait before you did that if you have malaria?**

**IF THE SAME DAY RECORD AS 00**

**IF NOT SURE RECORD AS 99**

☐☐

**9. Did you do that alone?**

- 1) Yes ☐
- 2) No ☐ who with?.....
- 3) Maybe ☐

**10. Would you do any of the following things before going to the BHS/RHU/Hospital/BHW?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Tell an adult (pinaalam sa magulang) ☐
- 2) Take paracetamol/biogesic ☐
- 3) Take anti-malarial ☐

- 4) Take Bioflu/ Neozep ☐
- 5) Go to the Traditional healer (arbularyo/baylan/tongkol/hilot) ☐
- 6) Take herbal medicine (halamang ugat) ☐
- 7) Cool the body with towels (maglagay ng basing tela sa katawan) ☐
- 8) Other..... ☐

**11. If you went to the BHS/RHU/Hospital/BHW with malaria would you expect them to do any of following?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Give you a check up ☐
- 2) Give you a smear test for malaria ☐
- 3) Give paracetamol/biogesic ☐
- 4) Give an anti-malarial ☐
- 5) Other..... ☐

**NOW GO TO QUESTION 17**

**12. How many hours or days would you wait before you did that if you have malaria?**

**IF THE SAME DAY RECORD AS 00**

**IF NOT SURE RECORD AS 99**

☐☐

**13. Did you do that alone?**

- 1) Yes ☐
- 2) No ☐ who with?.....
- 3) Maybe ☐

**14. Would you do any of the following things before going to arbularyos/balayan/tonkol/hilot?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Tell an adult (pinaalam sa magulang) ☐
- 2) Take paracetamol/biogesic ☐
- 3) Take anti-malarial ☐
- 4) Take Bioflu/Neozep ☐
- 5) Take herbal medicine (halamang ugat) ☐
- 6) Cool the body with towels/steaming (maglagay ng basing tela sa katawan) ☐
- 7) Go to the Barangay Health Centre ☐
- 8) Go the Rural Health Unit ☐
- 9) Go to the Barangay Health Worker ☐
- 10) Go to the hospital ☐
- 11) Other.....☐

**NOW GO TO QUESTION 17**

**15. How many hours or days would you wait before you did that if you have malaria?**

**IF THE SAME DAY RECORD AS 00**

**IF NOT SURE RECORD AS 99**

☐☐

**16. Did you do that alone?**

- 1) Yes ☐
- 2) No ☐ who with?.....
- 3) Maybe ☐

**NOW GO TO QUESTION 17**

**17. After the first action, if you did not get better, how long would you wait to see the result?**

**TICK ONE ANSWER**

- 1) Less than 30 minutes ☐
- 2) 30 minutes to 1 hour ☐
- 3) More than 1 hour on same day ☐
- 4) Next day ☐
- 5) 3-7 days ☐
- 6) Over 7 days ☐
- 7) Other..... ☐

**18. If you still did not get better, which one of the following would you do next?**

**READ LIST AND TICK ONE ANSWER**

- 1) Go to the Barangay Health Centre ☐
- 2) Go to the Barangay Health Worker ☐
- 3) Go the Rural Health Unit ☐
- 4) Go to the hospital ☐
- 5) Go to the Traditional healer (arbularyo/balyan/tongkol/hilot) ☐
- 6) Take herbal medicine (halamang ugat) ☐
- 7) Cool the body with towels/steaming (maglagay ng basing tela sa katawan) ☐
- 8) Nothing ☐
- 9) Tell an adult (pinaalam sa magulang) ☐
- 10) Take paracetamol/biogesic ☐
- 11) Take anti-malarial ☐
- 12) Take Bioflu/Neozep ☐
- 13) Other.....☐

**19. Did you do that alone?**

- 1) Yes ☐
- 2) No ☐ who with?.....
- 3) Maybe ☐

**NOW GO TO QUESTION 20**

**20. Have you had malaria in the last 30 days?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**IF 1 GO TO QUESTION 21**

**IF 2 OR 3 GO TO PART 5: MEDICINES FOR MALARIA**

**21. The last time you had malaria, which of the following signs did you have?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- |  |                          |
|--|--------------------------|
| 1) Headache (sakit ng ulo)                   | <input type="checkbox"/> |
| 2) High temperature/fever (lagnat)           | <input type="checkbox"/> |
| 3) Chilling (panginginig)                    | <input type="checkbox"/> |
| 4) Body pain (sakit ng katawan)              | <input type="checkbox"/> |
| 5) Sweating (pag pawis)                      | <input type="checkbox"/> |
| 6) Loss of appetite (walang gana kumain)     | <input type="checkbox"/> |
| 7) Loss of energy/feeling tired (panghihina) | <input type="checkbox"/> |
| 8) Dizziness (nahihilo)                      | <input type="checkbox"/> |
| 9) Coughing/flu (pag ubo/sipon)              | <input type="checkbox"/> |
| 10) Vomiting (pag susuka)                    | <input type="checkbox"/> |
| 11) Diarrhoea (pag tatae)                    | <input type="checkbox"/> |
| 12) Diarrhoea and vomiting (suka tae)        | <input type="checkbox"/> |

**22. Did you have a test to confirm you had malaria?**

- |             |                          |
|-------------|--------------------------|
| 1) Yes      | <input type="checkbox"/> |
| 2) No       | <input type="checkbox"/> |
| 3) Not sure | <input type="checkbox"/> |

**23. The last time you got malaria what is the first thing you did?**

**TICK ONE ANSWER**

- |   |                          |
|---|--------------------------|
| 1) Go to the Barangay Health Centre                               | <input type="checkbox"/> |
| 2) Go the Rural Health Unit                                       | <input type="checkbox"/> |
| 3) Go to the Barangay Health Worker                               | <input type="checkbox"/> |
| 4) Go to the hospital   | <input type="checkbox"/> |
| 5) Go to the traditional healer (arbularyo/baylan/tongkol/hilot)  | <input type="checkbox"/> |
| 6) Take herbal medicine (halamang ugat)                           | <input type="checkbox"/> |
| 7) Cool the body with towels (maglagay ng basing tela sa katawan) | <input type="checkbox"/> |
| 8) Take paracetamol/biogesic                                      | <input type="checkbox"/> |
| 9) Take an anti-malarial  | <input type="checkbox"/> |
| 10) Take Bioflu/Neozep  | <input type="checkbox"/> |
| 11) Other.....  | <input type="checkbox"/> |
| 12) Nothing   | <input type="checkbox"/> |
| 13) Tell an adult (pinaalam sa magulang)                          | <input type="checkbox"/> |

**IF 1-5 GO TO QUESTION 24**

**IF 6 GO TO QUESTION 29**

**IF 7-11 GO TO QUESTION 33**

**IF 12- 13 GO TO PART 5: MEDICINES FOR MALARIA**

**24. How many hours or days did you wait before you that when you had malaria?**

**IF THE SAME DAY RECORD AS 00**



**IF NOT SURE RECORD AS 99**

[\_][\_]

**25. Did you do that alone?**

- 1) Yes [\_]
- 2) No [\_] who with?.....
- 3) Maybe [\_]

**26. The last time you had malaria did you do any of the following things before going to the BHS/RHU/Hospital/BHW?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Tell an adult (teacher, parent, guardian) [\_]
- 2) Take paracetamol/biogesic [\_]
- 3) Take anti-malarial [\_]
- 4) Take Bioflu/Nusip [\_]
- 5) Go to the Traditional healer (arbularyo/balayan/tonkol/hilot) [\_]
- 6) Take herbal medicine [\_]
- 7) Cool the body with towels/steaming [\_]
- 8) Other..... [\_]

**27. When you went to the BHS/RHU/Hospital/BHW did they do any of following?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Give you a check up [\_]
- 2) Give you a smear test for malaria [\_]
- 3) Give paracetamol/biogesic [\_]
- 4) Give an anti-malarial [\_]
- 5) Other..... [\_]

**28. Was the treatment given by the BHS/RHU/Hospital/BHW effective?**

- 1) Yes [\_]
- 2) No [\_]
- 3) Not sure [\_]

**IF 2 GO TO QUESTION 36**

**IF 1 OR 3 GO TO PART 5: MEDICINES FOR MALARIA**

**29. How many hours or days did you wait before you that when you had malaria?**

**IF THE SAME DAY RECORD AS 00**

**IF NOT SURE RECORD AS 99**

[\_][\_]

**30. Did you do that alone?**

- 1) Yes [\_]
- 2) No [\_] who with?.....
- 3) Maybe [\_]

**31. The last time you had malaria did you do any of the following things before going to arbularyos/balayan/tonkol/hilot?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Tell an adult (pinaalam sa magulang) ☐
- 2) Take paracetamol/biogesic ☐
- 3) Take anti-malarial ☐
- 4) Take Bioflu/Neozep ☐
- 5) Take herbal medicine (halamang ugat) ☐
- 6) Cool the body with towels/steaming (maglagay ng basing tela sa katawan) ☐
- 7) Go to the Barangay Health Centre ☐
- 8) Go the Rural Health Unit ☐
- 9) Go to the Barangay Health Worker ☐
- 10) Go to the hospital ☐
- 11) Other.....☐

**32. Was the treatment given by the arbulatory/balayan/tonkol/hilot effective?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**IF 2 GO TO QUESTION 36**

**IF 1 OR 3 GO TO PART 5: MEDICINES FOR MALARIA**

**33. How many hours or days did you wait before you that when you had malaria?**

**IF THE SAME DAY RECORD AS 00**

**IF NOT SURE RECORD AS 99**

☐☐

**34. Did you do that alone?**

- 1) Yes ☐
- 2) No ☐ who with?.....
- 3) Maybe ☐

**35. Was the treatment effective?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**IF 2 GO TO QUESTION 36**

**IF 1 OR 3 GO TO PART 5: MEDICINES FOR MALARIA**

**36. After the first action, how long did you wait to see if there was a result?**

**TICK ONE ANSWER**

- 1) Less than 30 minutes ☐
- 2) 30 minutes to 1 hour ☐
- 3) More than 1 hour on same day ☐
- 4) Next day ☐

- 5) 3-7 days ☐
- 6) Over 7 days ☐
- 7) Other..... ☐

**37. After the first treatment was not effective, which one of the following did you do next?**

**READ LIST**

**TICK ONE ANSWER**

- 1) Go to the Barangay Health Centre ☐
- 2) Go to the Barangay Health Worker ☐
- 3) Go the Rural Health Unit ☐
- 4) Go to the hospital ☐
- 5) Go to the Traditional healer (arbularyo/balyan/tongkol/hilot) ☐
- 6) Take herbal medicine (halamang ugat) ☐
- 7) Cool the body with towels/steaming (maglagay ng basing tela sa katawan) ☐
- 8) Nothing ☐
- 9) Tell an adult (pinaalam sa magulang) ☐
- 10) Take paracetamol/biogesic ☐
- 11) Take anti-malarial ☐
- 12) Take Bioflu/Neozep ☐
- 13) Other..... ☐

**38. How many hours or days did you wait before you that when you had malaria?**

**IF THE SAME DAY RECORD AS 00**

**IF NOT SURE RECORD AS 99**

☐☐

**39. Did you do that alone?**

- 1) Yes ☐
- 2) No ☐ who with?.....
- 3) Maybe ☐

**40. Was the treatment you were given this time effective?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**NOW GO TO PART 5: MEDICINES FOR MALARIA**

## Part 5: Medicines for Malaria

**1. How many medicines for malaria (excluding herbal) can you name?**

[ ] [ ]

**LIST MEDICINES MENTIONED**

-----  
-----  
-----  
-----  
-----  
-----

**2. Have you ever bought/got medicines (excluding herbal) for malaria yourself without asking an adult first?**

- 1) Yes            [ ]  
2) No            [ ]  
3) Not sure      [ ]

**IF 1 GO TO QUESTION 3**

**IF 2 OR 3 GO TO QUESTION 4**

**3. Have you bought/got medicines for malaria from any of the following without asking an adult first?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Friends/family/neighbours [ ]  
2) Sari Sari store            [ ]  
3) Market                    [ ]  
4) Pharmacy                [ ]  
5) Barangay Health Worker [ ]  
6) BHS/RHU/Hospital      [ ]  
7) Anywhere else?.....[ ]

**NOW GO TO QUESTION 4**

**4. Have you ever taken medicines (excluding herbal) for malaria without asking an adult first?**

- 1) Yes            [ ]  
2) No            [ ]  
3) Not sure      [ ]

**5. Have you ever given medicines (excluding herbal) for malaria to any of the following without asking an adult first?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Family members younger than you ☐
- 2) Family members the same age as you ☐
- 3) Family members older than you ☐
- 4) Non family members younger than you ☐
- 5) Non family members the same age as you ☐
- 6) Non family members older than you ☐

**6. How many herbal medicines for malaria can you name?**

☐☐

**LIST MEDICINES MENTIONED**

-----

-----

-----

-----

-----

-----

**7. Have you ever bought/got herbal medicines for malaria yourself without asking an adult first?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**IF 1 GO TO QUESTION 8**

**IF 2 OR 3 GO TO QUESTION 9**

**8. Have you bought/got herbal medicines for malaria from any of the following without asking an adult first?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Friends/family/neighbours ☐
- 2) Sari Sari store ☐
- 3) Market ☐
- 4) Pharmacy ☐
- 5) Barangay Health Worker ☐
- 6) BHS/RHU/Hospital ☐
- 7) Anywhere else?.....☐

**NOW GO TO QUESTION 9**

**9. Have you ever taken herbal medicines for malaria without asking an adult first?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**13. Have you ever given herbal medicines for malaria to any of the following without asking an adult first?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Family members younger than you ☐
- 2) Family members the same age as you ☐
- 3) Family members older than you ☐
- 4) Non family members younger than you ☐
- 5) Non family members the same age as you ☐
- 6) Non family members older than you ☐

**10. How far do you agree with this statement? Herbal medicine is effective for fever.**

- 1) Yes ☐ 2) Maybe ☐ 3) No ☐ 4) No opinion ☐

**11. How far do you agree with this statement? Medicine from the Rural Health Unit is effective for fever.**

- 1) Yes ☐ 2) Maybe ☐ 3) No ☐ 4) No opinion ☐

## Part 6: Mosquitoes/Nets

**1. Do you have a mosquito net in your house?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**IF 1 GO TO QUESTION 2**

**IF 2 OR 3 GO TO QUESTION 9**

**2. Do you agree with this statement? Everyone in my house sleeps under a net?**

- 1) Yes ☐
- 2) Maybe ☐
- 3) No ☐
- 4) No opinion ☐

**3. Did you sleep under a net last night?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**IF 1 OR 3 GO TO QUESTION 5**

**IF 2 GO TO QUESTION 4**

**4. Why didn't you sleep under a net last night?**

**TICK ONE ANSWER**

- 1) Not enough nets (hindi sapat ang dami ng kulambo)☐
- 2) Too hot inside the net (mainit saloob ng kulambo)☐
- 3) I did not sleep in my house last night (Natulog ako sa ibang bahay)☐
- 4) The net was not used (nakatago lang ang kulambo)☐
- 5) Other..... ☐
- 6) Not sure ☐

**5. Does your net currently have holes in it?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**6. If your net has holes, do you repair them?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**7. How often do you wash your net?**

**TICK ONE ANSWER**

- 1) Every week ☐
- 2) Every month ☐
- 3) Every 6 months ☐
- 4) Every year ☐
- 5) Never ☐
- 6) Not sure ☐

**8. Do you use your current net for anything else apart from sleeping?**

**TICK MORE THAN ONE ANSWER IF NECESSARY**

- 1) Fishing ☐
- 2) To keep animals ☐
- 3) Other..... ☐

**9. How far do you agree with this statement? Mosquitoes cause disease.**

- 1) Yes ☐ 2) Maybe ☐ 3) No ☐ 4) No opinion ☐

**10. How far do you agree with this statement? Mosquitoes cause fever.**

- 1) Yes ☐ 2) Maybe ☐ 3) No ☐ 4) No opinion ☐

**11. How far do you agree with this statement? Mosquitoes cause malaria.**

- 1) Yes ☐ 2) Maybe ☐ 3) No ☐ 4) No opinion ☐

**12. How far do you agree with this statement? There are a lot of mosquitoes where I live?**

- 1) Yes ☐ 2) Maybe ☐ 3) No ☐ 4) No opinion ☐

**13. Which of the following do you do reduce the number of mosquitoes?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Clean the surroundings (linisin ang paligid)☐
- 2) Burn leaves for smoke (magpa-pausok sa paligid palagi) ☐
- 3) Spray the house (Magpa bumba ng bahay)☐
- 4) Use a mosquito net while sleeping (gumamit ng kulambo sa pagtulog)☐
- 5) Cut plants (bawasan ang sanga ng mga halaman) ☐
- 6) Keep animals close to the house (magtali ng hayop malapit sa bahay)☐
- 7) Drain stagnant water (ibuhos ang mga na istak na tubig sa paligid) ☐
- 8) Anything else?..... ☐

**14. Which of the following do you do reduce the number of mosquito bites that you get?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Wear long sleeves (pag-suot ng mahabang manggas)☐
- 2) Use mosquito nets (pagamit ng kulambo)☐
- 3) Use repellents (pagpahid ng panguntra sa lamok (e.g. off lotion) ☐
- 4) Slap mosquitoes off the skin (pagpatay sa lamok)☐
- 5) Use electric mosquito killer (Pangpatay sa lamok na dikuryente) ☐
- 6) Avoid staying out after dark (bago dumilim dapat na sa bahay na) ☐
- 7) Burn coils (katol) ☐
- 8) Anything else? ..... ☐



## Part 7: Self-esteem

### 1. To what extent do you agree with the following statements?

1=Definitely agree, 2= Agree, 3= Disagree, 4=Definitely disagree

- |   |                          |
|---|--------------------------|
| 1) On the whole, I am satisfied with myself                                 | <input type="checkbox"/> |
| 2) At times I think I am no good at all                                     | <input type="checkbox"/> |
| 3) I feel that I have a number of good qualities                            | <input type="checkbox"/> |
| 4) I am able to do things as well as most other people                      | <input type="checkbox"/> |
| 5) I feel I do not have much to be proud of                                 | <input type="checkbox"/> |
| 6) I certainly feel useless at times  | <input type="checkbox"/> |
| 7) I feel that I'm a person of worth, at least on a level equal with others | <input type="checkbox"/> |
| 8) All in all, I tend to feel that I'm a failure                            | <input type="checkbox"/> |
| 9) I take a positive attitude toward myself                                 | <input type="checkbox"/> |

## Part 8: Self-efficacy

### 1. To what extent are the following statements true?

1=Not at all true 2=Not really true 3=Nearly true 4= Exactly true

- |  |                          |
|--|--------------------------|
| 1) I can always manage to solve difficult problems if I try hard enough  | <input type="checkbox"/> |
| 2) If someone opposes me, I can find the means and ways to get what I want   | <input type="checkbox"/> |
| 3) It is easy for me to stick to my aims and accomplish my goals   | <input type="checkbox"/> |
| 4) I am confident that I could deal efficiently with unexpected events   | <input type="checkbox"/> |
| 5) Thanks to my resourcefulness, I know how to handle unforeseen situations  | <input type="checkbox"/> |
| 6) I can solve most problems if I invest the necessary effort  | <input type="checkbox"/> |
| 7) I can remain calm when facing difficulties because I can rely on my coping abilities                                | <input type="checkbox"/> |
| 8) When I am confronted with a problem, I can usually find several solutions   | <input type="checkbox"/> |
| 9) If I am in trouble, I can usually think of a solution   | <input type="checkbox"/> |
| 10) I can usually handle whatever comes my way   | <input type="checkbox"/> |
| 11) I am certain that I know how to recognise the symptoms of malaria without asking somebody else                     | <input type="checkbox"/> |
| 12) I am certain that I know where to go to be treated if I have malaria without asking somebody else                  | <input type="checkbox"/> |
| 13) I am certain that I know what medicine to take for malaria without asking somebody else                            | <input type="checkbox"/> |
| 14) I feel confident getting medicines for malaria myself without asking an adult first                                | <input type="checkbox"/> |
| 15) My parents trust me to get medicines for malaria myself without asking them first                                  | <input type="checkbox"/> |
| 16) I feel confident asking help from a health professional myself when i have malaria without asking my parents first | <input type="checkbox"/> |

- 17) My parents trust me to ask help from a health professional myself when I have malaria without asking them first [\_\_]
- 18) I am certain that I know how to recognise the symptoms of fever without asking somebody else [\_\_]
- 19) I am certain that I know where to go for treatment if I have fever without asking somebody else [\_\_]
- 20) I am certain that I know what medicine to take for fever without asking somebody else [\_\_]
- 21) I feel confident getting medicines for fever myself without asking an adult first [\_\_]
- 22) My parents trust me to get medicines for fever myself without asking them first [\_\_]
- 23) I feel confident asking help from a health professional myself when I have fever without asking my parents first [\_\_]
- 24) My parents trust me to ask help from a health professional myself when I have fever without asking them first [\_\_]
- 25) I feel confident talking to health professionals when I am sick [\_\_]
- 26) I feel health professionals take me seriously when I talk to them [\_\_]

## Appendix two

### Appendix two: Questionnaire for Adults – English Translation

Today's date

[ ][ ] \ [ ][ ] \ [ ][ ]

#### Part I: General Information

**1. Name**

.....  
(first name), (middle name), (second name)

**2. Name of adolescent enrolled in project**

.....  
(first name), (middle name), (second name)

**3. Relationship to adolescent in project (e.g. mother, father, grandmother, aunty)**

.....

**4. Do you live in the same house as the adolescent enrolled in the study?**

- 1) Yes            [ ]
- 2) No            [ ]
- 3) Not sure    [ ]

**5. Village you live in**

.....

**6. Age**

**IF NOT SURE RECORD AS 99**

[ ][ ]

**7. Sex**

- 1) Male            [ ]
- 2) Female        [ ]

**8. Are you married or not?**

- 1) Married            [ ]
- 2) Single            [ ]
- 3) Widowed        [ ]
- 4) Divorced        [ ]
- 5) Other ..... [ ]

**9. Religion**

- 1) Native/Palawano    [ ]
- 2) Islam            [ ]
- 3) Christian        [ ]
- 4) Other ..... [ ]
- 5) No religion        [ ]

**10. Ethnic group**

- 1) Palawano            [ ]
- 2) Other ..... [ ]

**11. Education level reached?**

- 1) Grade 1-3 ☐
- 2) Grade 4 ☐
- 3) Grade 5 ☐
- 4) Grade 7 ☐
  
- 5) High School ☐
- 6) No education ☐
- 7) Other..... ☐

**12. Work or occupation?**

**TICK MORE THAN ONE IF NECESSARY**

- 1) Student ☐
- 2) Farmer ☐
- 3) Casual worker ☐
- 4) No occupation ☐
- 5) House wife/husband ☐
- 6) Other..... ☐

**13. How many children do you have?**

☐☐

**14. What is the main source of drinking water?**

**TICK ONE ANSWER**

- 1) Piped water ☐
- 2) Pump ☐
- 3) Dug well ☐
- 4) Water from spring ☐
- 5) Rainwater ☐
- 6) Surface water (river, stream) ☐
- 7) Bottled water ☐
- 8) Other..... ☐

**15. What kind of toilet facilities do you have?**

**TICK ONE ANSWER**

- 1) Flush or pour flush toilet ☐
- 2) Pit ☐
- 3) Bucket toilet ☐
- 4) No facility/bush/field ☐
- 5) Other..... ☐

**16. Do you have any of the following items?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Electricity ☐
- 2) A radio ☐
- 3) A television ☐
- 4) A cell phone ☐
- 5) A bicycle ☐
- 6) A motor/tricycle/car/truck ☐

**17. What do you think are the three main illnesses that affect young people [aged 10-19] in your village?**

**RANK 1-3 IN ORDER MENTIONED**

- 1) Malaria ☐
- 2) Fever ☐
- 3) Cholera ☐
- 4) Vomiting ☐
- 5) Diarrhoea ☐
- 6) Diarrhoea and vomiting ☐
- 7) Headache ☐
- 8) Typhoid ☐
- 9) UTI ☐
- 10) Coughing/flu ☐
- 11) Spirits ☐
- 12) None ☐
- 13) Other..... ☐

**18. What do you think are the three main illnesses that affect adults in your village?**

**RANK 1-3 IN ORDER MENTIONED**

- 1) Malaria ☐
- 2) Fever ☐
- 3) Cholera ☐
- 4) Vomiting ☐
- 5) Diarrhoea ☐
- 6) Diarrhoea and vomiting ☐
- 7) Headache ☐
- 8) Typhoid ☐
- 9) UTI ☐
- 10) Coughing/flu ☐
- 11) Spirits ☐
- 12) None ☐
- 13) Other..... ☐

## Part 2: Fever

**1. Do you agree with this statement? Fever is a problem in my village.**

- 1) Yes ☐ 2) Maybe ☐ 3) No ☐ 4) No opinion ☐

**2. Do you agree with this statement? Fever is a dangerous illness.**

- 1) Yes ☐ 2) Maybe ☐ 3) No ☐ 4) No opinion ☐

**3. Do the following written below cause a person to have fever?**

**READ LIST.**

**1= Definitely yes, 2=maybe yes, 3=Neutral, 4=maybe no, 5=Definitely no**

- 1) Change in climate ☐
- 2) Working too much without rest /fatigue ☐
- 3) Hunger ☐
- 4) Dirty food ☐
- 5) Coconut juice ☐
- 6) Dirty water ☐
- 7) Dirty surroundings ☐
- 8) Mosquitoes ☐
- 9) Typhoid ☐
- 10) Malaria ☐
- 11) UTI ☐
- 12) Vomiting ☐
- 13) Diarrhoea ☐
- 14) Diarrhoea and vomiting ☐
- 15) Flu ☐
- 16) Spirits ☐

**4. If you became sick with fever which of the following would you do first?**

**READ LIST AND TICK ONE ANSWER**

- 1) Go to the Barangay Health Centre ☐
- 2) Go the Rural Health Unit ☐
- 3) Go to the Barangay Health Worker ☐
- 4) Go to the hospital ☐
- 5) Go to the traditional healer (arbularyo/baylan/tongkol/hilot) ☐
- 6) Take herbal medicine (halamang ugat) ☐
- 7) Cool the body with towels (maglagay ng basing tela sa katawan) ☐
- 8) Take paracetamol/biogesic ☐
- 9) Take an anti-malarial ☐
- 10) Take Bioflu/Neozep ☐
- 11) Other..... ☐
- 12) Nothing ☐

**IF 1-4 GO TO QUESTION 5**

**IF 5 GO TO QUESTION 8**

**IF 6-11 GO TO QUESTION 10**

**IF 12 GO TO QUESTION 13**

**5. How many hours or days would you wait before you did that when you have fever?**

**IF THE SAME DAY RECORD AS 00**

**IF NOT SURE RECORD AS 99**

☐☐

**6. Would you do any of the following things before going to the BHS/RHU/Hospital/BHW?**  
**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Take paracetamol/biogesic ☐
- 2) Take anti-malarial ☐
- 3) Take Bioflu/ Neozep ☐
- 4) Go to the Traditional healer (arbularyo/baylan/tongkol/hilot) ☐
- 5) Take herbal medicine (halamang ugat) ☐
- 6) Cool the body with towels (maglagay ng basing tela sa katawan) ☐
- 7) Other..... ☐

**7. If you went to the BHS/RHU/Hospital/BHW with fever would you expect them to do any of following?**  
**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Give you a check up ☐
- 2) Give you a smear test for malaria ☐
- 3) Give paracetamol/biogesic ☐
- 4) Give an anti-malarial ☐
- 5) Other..... ☐

**NOW GO TO QUESTION 11**

**8. How many hours or days would you wait before you did that when you have fever?**

**IF THE SAME DAY RECORD AS 00**

**IF NOT SURE RECORD AS 99**

☐☐

**9. Would you do any of the following things before going to arbularyos/balayan/tonkol/hilot?**  
**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Take paracetamol/biogesic ☐
- 2) Take anti-malarial ☐
- 3) Take Bioflu/Neozep ☐
- 4) Take herbal medicine (halamang ugat) ☐
- 5) Cool the body with towels/steaming (maglagay ng basing tela sa katawan) ☐
- 6) Go to the Barangay Health Centre ☐
- 7) Go the Rural Health Unit ☐
- 8) Go to the Barangay Health Worker ☐
- 9) Go to the hospital ☐
- 10) Other..... ☐

**NOW GO TO QUESTION 11**

**10. How many hours or days would you wait before you did that when you have fever?**

**IF THE SAME DAY RECORD AS 00**

**IF NOT SURE RECORD AS 99**

**NOW GO TO QUESTION 11**

**11. After the first action, how long would you wait to see the result?**

**READ LIST**

**TICK ONE ANSWER**

- |                                 |                          |
|---------------------------------|--------------------------|
| 1) Less than 30 minutes         | <input type="checkbox"/> |
| 2) 30 minutes to 1 hour         | <input type="checkbox"/> |
| 3) More than 1 hour on same day | <input type="checkbox"/> |
| 4) Next day                     | <input type="checkbox"/> |
| 5) 3-7 days                     | <input type="checkbox"/> |
| 6) Over 7 days                  | <input type="checkbox"/> |
| 7) Other.....                   | <input type="checkbox"/> |

**12. If you still did not get better, which one of the following would you do next?**

**READ LIST**

**TICK ONE ANSWER**

- |  |                          |
|--|--------------------------|
| 1) Go to the Barangay Health Centre  | <input type="checkbox"/> |
| 2) Go to the Barangay Health Worker  | <input type="checkbox"/> |
| 3) Go to the Rural Health Unit   | <input type="checkbox"/> |
| 4) Go to the hospital  | <input type="checkbox"/> |
| 5) Go to the Traditional healer (arbularyo/balyan/tongkol/hilot)           | <input type="checkbox"/> |
| 6) Take herbal medicine (halamang ugat)                                    | <input type="checkbox"/> |
| 7) Cool the body with towels/steaming (maglagay ng basing tela sa katawan) | <input type="checkbox"/> |
| 8) Nothing   | <input type="checkbox"/> |
| 9) Take paracetamol/biogesic   | <input type="checkbox"/> |
| 10) Take anti-malarial   | <input type="checkbox"/> |
| 11) Take Bioflu/Neozep   | <input type="checkbox"/> |
| 12) Other.....   | <input type="checkbox"/> |

**NOW GO TO QUESTION 13**

**13. Have you had fever in the last 30 days?**

- |             |                          |
|-------------|--------------------------|
| 1) Yes      | <input type="checkbox"/> |
| 2) No       | <input type="checkbox"/> |
| 3) Not sure | <input type="checkbox"/> |

**IF 1 GO TO QUESTION 14**

**IF 2 OR 3 GO TO PART 3: MEDICINES FOR FEVER**

**14. The last time you had fever, which of the following signs did you have?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**



- |                                 |                          |
|---------------------------------|--------------------------|
| 1) Headache                     | <input type="checkbox"/> |
| 2) High temperature/fever       | <input type="checkbox"/> |
| 3) Chilling                     | <input type="checkbox"/> |
| 4) Body pain                    | <input type="checkbox"/> |
| 5) Sweating                     | <input type="checkbox"/> |
| 6) Loss of appetite             | <input type="checkbox"/> |
| 7) Loss of energy/feeling tired | <input type="checkbox"/> |
| 8) Dizziness                    | <input type="checkbox"/> |
| 9) Vomiting                     | <input type="checkbox"/> |
| 10) Coughing                    | <input type="checkbox"/> |
| 11) Diarrhoea                   | <input type="checkbox"/> |

**15. The last time you got fever what is the first thing you did?**

**TICK ONE ANSWER**

- |  |                          |
|--|--------------------------|
| 1) Go to the Barangay Health Centre  | <input type="checkbox"/> |
| 2) Go the Rural Health Unit  | <input type="checkbox"/> |
| 3) Go to the Barangay Health Worker  | <input type="checkbox"/> |
| 4) Go to the hospital  | <input type="checkbox"/> |
| 5) Go to the traditional healer (arbularyo/balyan/tongkol/hilot)           | <input type="checkbox"/> |
| 6) Take herbal medicine (halamang ugat)                                    | <input type="checkbox"/> |
| 7) Cool the body with towels/steaming (maglagay ng basing tela sa katawan) | <input type="checkbox"/> |
| 8) Take paracetamol/biogesic   | <input type="checkbox"/> |
| 9) Take an anti-malarial   | <input type="checkbox"/> |
| 10) Take Bioflu/Nusip  | <input type="checkbox"/> |
| 11) Other.....   | <input type="checkbox"/> |
| 12) Nothing  | <input type="checkbox"/> |

**IF 1-5 GO TO QUESTION 16**

**IF 6 GO TO QUESTION 20**

**IF 7-11 GO TO QUESTION 23**

**IF 12 GO TO PART 3: MEDICINES FOR FEVER**

**16. How many hours or days would you wait before you did that when you have fever?**

**IF THE SAME DAY RECORD AS 00**

**IF NOT SURE RECORD AS 99**

☐☐

**17. The last time you had fever did you do any of the following things before going to the BHS/RHU/Hospital/BHW?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- |  |                          |
|--|--------------------------|
| 1) Take paracetamol/biogesic                                     | <input type="checkbox"/> |
| 2) Take anti-malarial  | <input type="checkbox"/> |
| 3) Take Bioflu/Nusip   | <input type="checkbox"/> |
| 4) Go to the Traditional healer (arbularyo/balayan/tonkol/hilot) | <input type="checkbox"/> |
| 5) Take herbal medicine  | <input type="checkbox"/> |
| 6) Cool the body with towels/steaming                            | <input type="checkbox"/> |
| 7) Other.....  | <input type="checkbox"/> |

**18. When you went to the BHS/RHU/Hospital/BHW did they do any of following?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Give you a check up ☐
- 2) Give you a smear test for malaria ☐
- 3) Give paracetamol/biogesic ☐
- 4) Give an anti-malarial ☐
- 5) Other..... ☐

**19. Was the treatment given by the BHS/RHU/Hospital/BHW effective?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**IF 2 GO TO QUESTION 25**

**IF 1 OR 3 GO TO PART 3: MEDICINES FOR FEVER**

**20. How many hours or days would you wait before you did that when you have fever?**

**IF THE SAME DAY RECORD AS 00**

**IF NOT SURE RECORD AS 99**

**21. The last time you had fever did you do any of the following things before going to  
arbularyos/balayan/tonkol/hilot?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Take paracetamol/biogesic ☐
- 2) Take anti-malarial ☐
- 3) Take Bioflu/Nusip ☐
- 4) Take herbal medicine ☐
- 5) Cool the body with towels/steaming ☐
- 6) Go to the Barangay Health Centre ☐
- 7) Go the Rural Health Centre ☐
- 8) Go to the Barangay Health Worker ☐
- 9) Go to the hospital ☐
- 10) Other..... ☐

**22. Was the treatment given by the arbularyos/balayan/tonkol/hilot effective?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**IF 2 GO TO QUESTION 25**

**IF 1 OR 3 GO TO PART 3: MEDICINES FOR FEVER**

**23. How many hours or days would you wait before you did that when you have fever?**

**IF THE SAME DAY RECORD AS 00**

**IF NOT SURE RECORD AS 99**

**24. Was the treatment effective?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**IF 2 GO TO QUESTION 25**

**IF 1 OR 3 GO TO PART 3: MEDICINES FOR FEVER**

**25. After the first action, how long did you wait to see the result?**

- 1) Less than 30 minutes ☐
- 2) 30 minutes to 1 hour ☐
- 3) More than 1 hour on same day ☐
- 4) Next day ☐
- 5) 3-7 days ☐
- 6) Over 7 days ☐
- 7) Other..... ☐

**26. After the first treatment was not effective, which one of the following did you do next?**

**READ LIST AND TICK ONE ANSWER**

- 1) Go to the Barangay Health Centre ☐
- 2) Go to the Barangay Health Worker ☐
- 3) Go the Rural Health Centre ☐
- 4) Go to the hospital ☐
- 5) Go to the Traditional healer (arbularyo/balayan/tonkol/hilot) ☐
- 6) Take herbal medicine ☐
- 7) Cool the body with towels/steaming ☐
- 8) Nothing ☐
- 9) Take paracetamol/biogesic ☐
- 10) Take anti-malarial ☐
- 11) Take Bioflu/Nusip ☐
- 12) Other..... ☐

**27. Was the treatment you were given this time effective?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**NOW GO TO PART 3: MEDICINES FOR FEVER**

## Part 3: Medicines for fever

### 1. How many medicines for fever (excluding herbal) do you know?

[ ] [ ]

#### LIST MEDICINES MENTIONED

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-----  
-----  
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-----  
-----

### 1. Have you bought/got medicines for fever (excluding herbal) from any of the following?

#### READ LIST

1=Yes, 2= No, 3=Not sure

- |                              |     |
|------------------------------|-----|
| 1) Friends/family/neighbours | [ ] |
| 2) Sari Sari store           | [ ] |
| 3) Market                    | [ ] |
| 4) Pharmacy                  | [ ] |
| 5) Barangay Health Worker    | [ ] |
| 6) BHS/RHU/Hospital          | [ ] |
| 7) Other .....               | [ ] |

### 2. Have you ever given medicines (excluding herbal) for fever to any of the following?

#### READ LIST

1=Yes, 2= No, 3=Not sure

- |   |     |
|---|-----|
| 1) Family members younger than you        | [ ] |
| 2) Family members the same age as you     | [ ] |
| 3) Family members older than you          | [ ] |
| 4) Non-family members younger than you    | [ ] |
| 5) Non-family members the same age as you | [ ] |
| 6) Non-family members older than you      | [ ] |

### 3. How many herbal medicines for fever do you know?

[ ] [ ]

#### LIST MEDICINES MENTIONED

-----  
-----  
-----  
-----  
-----

-----

**2. Have you bought/got medicines for fever (excluding herbal) from any of the following?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- |                              |                          |
|------------------------------|--------------------------|
| 1) Friends/family/neighbours | <input type="checkbox"/> |
| 2) Sari Sari store           | <input type="checkbox"/> |
| 3) Market                    | <input type="checkbox"/> |
| 4) Pharmacy                  | <input type="checkbox"/> |
| 5) Barangay Health Worker    | <input type="checkbox"/> |
| 6) BHS/RHU/Hospital          | <input type="checkbox"/> |
| 7) Other .....               | <input type="checkbox"/> |

**4. Have you ever given herbal medicines for fever to any of the following?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- |   |                          |
|---|--------------------------|
| 1) Family members younger than you        | <input type="checkbox"/> |
| 2) Family members the same age as you     | <input type="checkbox"/> |
| 3) Family members older than you          | <input type="checkbox"/> |
| 4) Non family members younger than you    | <input type="checkbox"/> |
| 5) Non family members the same age as you | <input type="checkbox"/> |
| 6) Non family members older than you      | <input type="checkbox"/> |

**5. How far do you agree with this statement? Herbal medicine is effective for fever.**

- 1) Yes ☐ 2) Maybe ☐ 3) No ☐ 4) No opinion ☐

**6. How far do you agree with this statement? Medicine from the Rural Health Unit is effective for fever.**

- 1) Yes ☐ 2) Maybe ☐ 3) No ☐ 4) No opinion ☐

## Part 4: Malaria

### 1. How far do you agree with this statement? Malaria is a problem in my village.

- 1) Yes ☐ 2) Maybe ☐ 3) No ☐ 4) No opinion ☐

### 2. How far do you agree with this statement? Malaria is a dangerous illness.

- 1) Yes ☐ 2) Maybe ☐ 3) No ☐ 4) No opinion ☐

### 3. Where have you read or heard information about malaria?

#### READ LIST

1=Yes, 2= No, 3=Not sure

- |   |                          |
|---|--------------------------|
| 1) Radio                                  | <input type="checkbox"/> |
| 2) TV                                     | <input type="checkbox"/> |
| 3) Posters/pamphlets                      | <input type="checkbox"/> |
| 4) School                                 | <input type="checkbox"/> |
| 5) Teachers                               | <input type="checkbox"/> |
| 6) Friends/family who are adults          | <input type="checkbox"/> |
| 7) Friends/family who are young people    | <input type="checkbox"/> |
| 8) Health workers (e.g. BHS or RHU staff) | <input type="checkbox"/> |
| 9) Other .....                            | <input type="checkbox"/> |

### 4. Do you agree that each of the following can cause a person to have malaria?

1= Definitely yes, 2=maybe yes, 3=Neutral, 4=maybe no, 5=Definitely no

- |   |                          |
|---|--------------------------|
| 1) Changes in weather                     | <input type="checkbox"/> |
| 2) Working too much without rest /fatigue | <input type="checkbox"/> |
| 3) Hunger                                 | <input type="checkbox"/> |
| 4) Dirty food                             | <input type="checkbox"/> |
| 5) Coconut juice                          | <input type="checkbox"/> |
| 6) Dirty water                            | <input type="checkbox"/> |
| 7) Dirty surroundings                     | <input type="checkbox"/> |
| 8) Mosquitoes                             | <input type="checkbox"/> |

### 5. Do you do any of the following to prevent malaria?

#### READ LIST

1=Yes, 2= No, 3=Not sure

- |                                      |                          |
|--------------------------------------|--------------------------|
| 1) Not stay out in the sun           | <input type="checkbox"/> |
| 2) Not work too much without rest    | <input type="checkbox"/> |
| 3) Clean the surroundings            | <input type="checkbox"/> |
| 4) Drink clean water only            | <input type="checkbox"/> |
| 5) Prepare food properly             | <input type="checkbox"/> |
| 6) Spray the house                   | <input type="checkbox"/> |
| 7) Use a mosquito net while sleeping | <input type="checkbox"/> |
| 8) Burn leaves for smoke             | <input type="checkbox"/> |
| 9) Other .....                       | <input type="checkbox"/> |

### 6. How far do you agree that each of the following are signs of malaria?

**1= Definitely yes, 2=maybe yes, 3=Neutral, 4=maybe no, 5=Definitely no**

- |                                 |                          |
|---------------------------------|--------------------------|
| 1) Headache                     | <input type="checkbox"/> |
| 2) High temperature/fever       | <input type="checkbox"/> |
| 3) Chilling                     | <input type="checkbox"/> |
| 4) Body pain                    | <input type="checkbox"/> |
| 5) Sweating                     | <input type="checkbox"/> |
| 6) Loss of appetite             | <input type="checkbox"/> |
| 7) Loss of energy/feeling tired | <input type="checkbox"/> |
| 8) Dizziness                    | <input type="checkbox"/> |
| 9) Coughing/flu                 | <input type="checkbox"/> |
| 10) Vomiting                    | <input type="checkbox"/> |
| 11) Diarrhoea                   | <input type="checkbox"/> |
| 12) Diarrhoea and vomiting      | <input type="checkbox"/> |

**7. If you became sick with malaria which of the following would you do first?**

**TICK ONE ANSWER**

- |  |                          |
|--|--------------------------|
| 1) Go to the Barangay Health Centre                              | <input type="checkbox"/> |
| 2) Go the Rural Health Centre                                    | <input type="checkbox"/> |
| 3) Go to the Barangay Health Worker                              | <input type="checkbox"/> |
| 4) Go to the hospital  | <input type="checkbox"/> |
| 5) Go to the traditional healer (arbularyo/balayan/tonkol/hilot) | <input type="checkbox"/> |
| 6) Take herbal medicine  | <input type="checkbox"/> |
| 7) Cool the body with towels                                     | <input type="checkbox"/> |
| 8) Take paracetamol/biogesic                                     | <input type="checkbox"/> |
| 9) Take an anti-malarial   | <input type="checkbox"/> |
| 10) Take Bioflu/Nusip  | <input type="checkbox"/> |
| 11) Other.....   | <input type="checkbox"/> |
| 12) Nothing  | <input type="checkbox"/> |

**IF 1-4 GO TO QUESTION 8**

**IF 5 GO TO QUESTION 11**

**IF 6-11 GO TO QUESTION 13**

**If 12 GO TO QUESTION 16**

**8. How many hours or days would you wait before you did that if you have malaria?**

**IF THE SAME DAY RECORD AS 00**

**IF NOT SURE RECORD AS 99**

**9. Would you do any of the following things before going to the BHS/RHU/Hospital/BHW?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- |  |                          |
|--|--------------------------|
| 1) Take paracetamol/biogesic                                     | <input type="checkbox"/> |
| 2) Take anti-malarial  | <input type="checkbox"/> |
| 3) Take Bioflu/Nusip   | <input type="checkbox"/> |
| 4) Go to the Traditional healer (arbularyo/balayan/tonkol/hilot) | <input type="checkbox"/> |
| 5) Take herbal medicine  | <input type="checkbox"/> |
| 6) Cool the body with towels/steaming                            | <input type="checkbox"/> |
| 7) Other.....  | <input type="checkbox"/> |

**10. If you went to the BHS/RHU/Hospital/BHW with malaria would you expect them to do any of following?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- |                                      |                          |
|--------------------------------------|--------------------------|
| 1) Give you a check up               | <input type="checkbox"/> |
| 2) Give you a smear test for malaria | <input type="checkbox"/> |
| 3) Give paracetamol/biogesic         | <input type="checkbox"/> |
| 4) Give an anti-malarial             | <input type="checkbox"/> |
| 5) Other.....                        | <input type="checkbox"/> |

**NOW GO TO QUESTION 14**

**11. How many hours or days would you wait before you did that if you have malaria?**

**IF THE SAME DAY RECORD AS 00**

**IF NOT SURE RECORD AS 99**

☐☐

**12. Would you do any of the following things before going to arbularyos/balayan/tonkol/hilot?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- |                                       |                          |
|---------------------------------------|--------------------------|
| 1) Take paracetamol/biogesic          | <input type="checkbox"/> |
| 2) Take anti-malarial                 | <input type="checkbox"/> |
| 3) Take Bioflu/Nusip                  | <input type="checkbox"/> |
| 4) Take herbal medicine               | <input type="checkbox"/> |
| 5) Cool the body with towels/steaming | <input type="checkbox"/> |
| 6) Go to the Barangay Health Centre   | <input type="checkbox"/> |
| 7) Go the Rural Health Centre         | <input type="checkbox"/> |
| 8) Go to the Barangay Health Worker   | <input type="checkbox"/> |
| 9) Go to the hospital                 | <input type="checkbox"/> |
| 10) Other.....                        | <input type="checkbox"/> |

**NOW GO TO QUESTION 14**

**13. How many hours or days would you wait before you did that if you have malaria?**

**IF THE SAME DAY RECORD AS 00**

**IF NOT SURE RECORD AS 99**

☐☐

**NOW GO TO QUESTION 14**

**14. After the first action, if you did not get better, how long would you wait to see the result?**

**TICK ONE ANSWER**

- |                                 |                          |
|---------------------------------|--------------------------|
| 1) Less than 30 minutes         | <input type="checkbox"/> |
| 2) 30 minutes to 1 hour         | <input type="checkbox"/> |
| 3) More than 1 hour on same day | <input type="checkbox"/> |
| 4) Next day                     | <input type="checkbox"/> |



- 5) 3-7 days ☐
- 6) Over 7 days ☐
- 7) Other..... ☐

**15. If you still did not get better, which one of the following would you do next?**

**READ LIST AND TICK ONE ANSWER**

- 1) Go to the Barangay Health Centre ☐
- 2) Go to the Barangay Health Worker ☐
- 3) Go the Rural Health Centre ☐
- 4) Go to the hospital ☐
- 5) Go to the Traditional healer (arbularyo/balayan/tonkol/hilot) ☐
- 6) Take herbal medicine ☐
- 7) Cool the body with towels/steaming ☐
- 8) Nothing ☐
- 9) Take paracetamol/biogesic ☐
- 10) Take anti-malarial ☐
- 11) Take Bioflu/Nusip ☐
- 12) Other..... ☐

**NOW GO TO QUESTION 16**

**16. Have you had malaria in the last 30 days?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**IF 1 GO TO QUESTION 17**

**IF 2 OR 3 GO TO PART 5: MEDICINES FOR MALARIA**

**17. The last time you had malaria, which of the following signs did you have?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Headache ☐
- 2) High temperature/fever ☐
- 3) Chilling ☐
- 4) Body pain ☐
- 5) Sweating ☐
- 6) Loss of appetite ☐
- 7) Loss of energy/feeling tired ☐
- 8) Dizziness ☐
- 9) Coughing/flu ☐
- 10) Vomiting ☐
- 11) Diarrhoea ☐
- 12) Diarrhoea and vomiting ☐

**18. Did you have a test to confirm you had malaria?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**19. The last time you got malaria what is the first thing you did?**

**TICK ONE ANSWER**

- |  |                          |
|--|--------------------------|
| 1) Go to the Barangay Health Centre                              | <input type="checkbox"/> |
| 2) Go the Rural Health Centre                                    | <input type="checkbox"/> |
| 3) Go to the Barangay Health Worker                              | <input type="checkbox"/> |
| 4) Go to the hospital  | <input type="checkbox"/> |
| 5) Go to the traditional healer (arbularyo/balayan/tonkol/hilot) | <input type="checkbox"/> |
| 6) Take herbal medicine  | <input type="checkbox"/> |
| 7) Cool the body with towels                                     | <input type="checkbox"/> |
| 8) Take paracetamol/biogesic                                     | <input type="checkbox"/> |
| 9) Take an anti-malarial   | <input type="checkbox"/> |
| 10) Take Bioflu/Nusip  | <input type="checkbox"/> |
| 11) Other.....   | <input type="checkbox"/> |
| 12) Nothing  | <input type="checkbox"/> |

**IF 1-5 GO TO QUESTION 20**

**IF 6 GO TO QUESTION 24**

**IF 7-11 GO TO QUESTION 27**

**IF 12- 13 GO TO PART 5: MEDICINES FOR MALARIA**

**20. How many hours or days did you wait before you that when you had malaria?**

**IF THE SAME DAY RECORD AS 00**

**IF NOT SURE RECORD AS 99**

**21. The last time you had malaria did you do any of the following things before going to the BHS/RHU/Hospital/BHW?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- |  |                          |
|--|--------------------------|
| 1) Take paracetamol/biogesic                                     | <input type="checkbox"/> |
| 2) Take anti-malarial  | <input type="checkbox"/> |
| 3) Take Bioflu/Nusip   | <input type="checkbox"/> |
| 4) Go to the Traditional healer (arbularyo/balayan/tonkol/hilot) | <input type="checkbox"/> |
| 5) Take herbal medicine  | <input type="checkbox"/> |
| 6) Cool the body with towels/steaming                            | <input type="checkbox"/> |
| 7) Other.....  | <input type="checkbox"/> |

**22. When you went to the BHS/RHU/Hospital/BHW what did they do to you?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- |                                      |                          |
|--------------------------------------|--------------------------|
| 1) Give you a check up               | <input type="checkbox"/> |
| 2) Give you a smear test for malaria | <input type="checkbox"/> |
| 3) Give paracetamol/biogesic         | <input type="checkbox"/> |
| 4) Give an anti-malarial             | <input type="checkbox"/> |
| 5) Other.....                        | <input type="checkbox"/> |

**23. Was the treatment given by the BHS/RHU/Hospital/BHW effective?**

- |        |                          |
|--------|--------------------------|
| 1) Yes | <input type="checkbox"/> |
|--------|--------------------------|

- 2) No ☐
- 3) Not sure ☐

**IF 2 GO TO QUESTION 29**

**IF 1 OR 3 GO TO PART 5: MEDICINES FOR MALARIA**

**24. How many hours or days did you wait before you that when you had malaria?**

**IF THE SAME DAY RECORD AS 00**

**IF NOT SURE RECORD AS 99**

**25. The last time you had malaria did you do any of the following things before going to arbularyos/balayan/tonkol/hilot?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- |                                       |                          |
|---------------------------------------|--------------------------|
| 1) Take paracetamol/biogesic          | <input type="checkbox"/> |
| 2) Take anti-malarial                 | <input type="checkbox"/> |
| 3) Take Bioflu/Nusip                  | <input type="checkbox"/> |
| 4) Take herbal medicine               | <input type="checkbox"/> |
| 5) Cool the body with towels/steaming | <input type="checkbox"/> |
| 6) Go to the Barangay Health Centre   | <input type="checkbox"/> |
| 7) Go the Rural Health Centre         | <input type="checkbox"/> |
| 8) Go to the Barangay Health Worker   | <input type="checkbox"/> |
| 9) Go to the hospital                 | <input type="checkbox"/> |
| 10) Other.....                        | <input type="checkbox"/> |

**26. Was the treatment given by the arbularyos/balayan/tonkol/hilot effective?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**IF 2 GO TO QUESTION 29**

**IF 1 OR 3 GO TO PART 5: MEDICINES FOR MALARIA**

**27. How many hours or days did you wait before you that when you had malaria?**

**IF THE SAME DAY RECORD AS 00**

**IF NOT SURE RECORD AS 99**

**28. Was the treatment effective?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**IF 2 GO TO QUESTION 29**

**IF 1 OR 3 GO TO PART 5: MEDICINES FOR MALARIA**

**29. After the first action, how long did you wait to see the result?**

- 1) Less than 30 minutes ☐

- 2) 30 minutes to 1 hour ☐
- 3) More than 1 hour on same day ☐
- 4) Next day ☐
- 5) 3-7 days ☐
- 6) Over 7 days ☐
- 7) Other..... ☐

**30. After the first treatment was not effective, which one of the following did you do next?**

**READ LIST AND TICK ONE ANSWER**

- 1) Go to the Barangay Health Centre ☐
- 2) Go to the Barangay Health Worker ☐
- 3) Go the Rural Health Centre ☐
- 4) Go to the hospital ☐
- 5) Go to the Traditional healer (arbularyo/balayan/tonkol/hilot) ☐
- 6) Take herbal medicine ☐
- 7) Cool the body with towels/steaming ☐
- 8) Nothing ☐
- 9) Take paracetamol/biogesic ☐
- 10) Take anti-malarial ☐
- 11) Take Bioflu/Nusip ☐
- 12) Other..... ☐

**31. Was the treatment you were given this time effective?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**NOW GO TO PART 5: MEDICINES FOR MALARIA**

## Part 5: Medicines for Malaria

3. How many medicines for malaria (excluding herbal) do you know?

[ ] [ ]

LIST MEDICINES MENTIONED

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-----  
-----  
-----  
-----

4. Have you bought/got medicines for malaria (excluding herbal) from any of the following?

READ LIST

1=Yes, 2= No, 3=Not sure

- |                              |     |
|------------------------------|-----|
| 1) Friends/family/neighbours | [ ] |
| 2) Sari Sari store           | [ ] |
| 3) Market                    | [ ] |
| 4) Pharmacy                  | [ ] |
| 5) Barangay Health Worker    | [ ] |
| 6) BHS/RHU/Hospital          | [ ] |
| 7) Other .....               | [ ] |

5. Have you ever given medicines (excluding herbal) for malaria to any of the following?

READ LIST

1=Yes, 2= No, 3=Not sure

- |   |     |
|---|-----|
| 1) Family members younger than you        | [ ] |
| 2) Family members the same age as you     | [ ] |
| 3) Family members older than you          | [ ] |
| 4) Non family members younger than you    | [ ] |
| 5) Non family members the same age as you | [ ] |
| 6) Non family members older than you      | [ ] |

6. How many herbal medicines for malaria do you know?

[ ] [ ]

LIST MEDICINES MENTIONED

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-----  
-----  
-----  
-----  
-----

**7. Have you bought/got herbal medicines for malaria from any of the following?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- |                              |                          |
|------------------------------|--------------------------|
| 1) Friends/family/neighbours | <input type="checkbox"/> |
| 2) Sari Sari store           | <input type="checkbox"/> |
| 3) Market                    | <input type="checkbox"/> |
| 4) Pharmacy                  | <input type="checkbox"/> |
| 5) Barangay Health Worker    | <input type="checkbox"/> |
| 6) BHS/RHU/Hospital          | <input type="checkbox"/> |
| 7) Other .....               | <input type="checkbox"/> |

**8. Have you ever given herbal medicines for malaria to any of the following?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- |   |                          |
|---|--------------------------|
| 1) Family members younger than you        | <input type="checkbox"/> |
| 2) Family members the same age as you     | <input type="checkbox"/> |
| 3) Family members older than you          | <input type="checkbox"/> |
| 4) Non family members younger than you    | <input type="checkbox"/> |
| 5) Non family members the same age as you | <input type="checkbox"/> |
| 6) Non family members older than you      | <input type="checkbox"/> |

**9. How far do you agree with this statement? Herbal medicine is effective for fever.**

- 1) Yes ☐ 2) Maybe ☐ 3) No ☐ 4) No opinion ☐

**10. How far do you agree with this statement? Medicine from the Rural Health Unit is effective for fever.**

- 1) Yes ☐ 2) Maybe ☐ 3) No ☐ 4) No opinion ☐

## Part 6: Mosquitoes/Nets

**1. Do you have a mosquito net in your house?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**IF 1 GO TO QUESTION 2**

**IF 2 OR 3 GO TO QUESTION 9**

**2. How far do you agree with this statement? Everyone in my house sleeps under a net?**

- 1) Definitely agree ☐ 2) Agree ☐ 3) Neutral ☐ 4) Disagree ☐ 5) Definitely disagree ☐

**3. Did you sleep under a net last night?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**IF 1 OR 3 GO TO QUESTION 5**

**IF 2 GO TO QUESTION 4**

**4. Why didn't you sleep under a net last night?**

**TICK ONE ANSWER**

- 1) Not enough nets ☐
- 2) Too hot inside the net ☐
- 3) I did not sleep in my house last night ☐
- 4) The net was not used ☐
- 5) Other..... ☐
- 6) Not sure ☐

**5. Does your net currently have holes in it?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**6. If your net has holes, do you repair them?**

- 1) Yes ☐
- 2) No ☐
- 3) Not sure ☐

**7. How often do you wash your net?**

**TICK ONE ANSWER**

- 1) Every week ☐
- 2) Every month ☐
- 3) Every 6 months ☐
- 4) Every year ☐
- 5) Never ☐
- 6) Not sure ☐

**8. Do you use your current net for anything else apart from sleeping?**

**TICK MORE THAN ONE ANSWER IF NECESSARY**

- 1) Fishing ☐
- 2) To keep animals ☐
- 3) Other..... ☐

**9. How far do you agree with this statement? Mosquitoes cause disease.**

- 1) Yes ☐ 2) Maybe ☐ 3) No ☐ 4) No opinion ☐

**10. How far do you agree with this statement? Mosquitoes cause fever.**

- 1) Yes ☐ 2) Maybe ☐ 3) No ☐ 4) No opinion ☐

**11. How far do you agree with this statement? Mosquitoes cause malaria.**

- 1) Yes ☐ 2) Maybe ☐ 3) No ☐ 4) No opinion ☐

**12. How far do you agree with this statement? There are a lot of mosquitoes where I live?**

- 1) Yes ☐ 2) Maybe ☐ 3) No ☐ 4) No opinion ☐

**13. Which of the following do you do reduce the number of mosquitoes?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Clean surroundings ☐
- 2) Burn leaves ☐
- 3) Spray houses ☐
- 4) Use mosquito nets ☐
- 5) Cut plants ☐
- 6) Keep animals close to the house ☐
- 7) Clear stagnant water ☐
- 8) Other ..... ☐

**14. Which of the following do you do reduce the number of mosquito bites that you get?**

**READ LIST**

**1=Yes, 2= No, 3=Not sure**

- 1) Wear long sleeves ☐
- 2) Use mosquito nets ☐
- 3) Use repellents (e.g. off lotion) ☐
- 4) Slap mosquitoes off the skin ☐
- 5) Use electric mosquito killer ☐
- 6) Avoid staying out after dark ☐
- 7) Burn coils ☐
- 8) Anything else? ..... ☐



## Part 7: Self-esteem

### 1. To what extent do you agree with the following statements?

1=Definitely agree, 2= Agree, 3= Disagree, 4=Definitely disagree

- 1) On the whole, I am satisfied with myself ☐
- 2) At times I think I am no good at all ☐
- 3) I feel that I have a number of good qualities ☐
- 4) I am able to do things as well as most other people ☐
- 5) I feel I do not have much to be proud of ☐
- 6) I certainly feel useless at times ☐
- 7) I feel that I'm a person of worth, at least on a level equal with others ☐
- 8) All in all, I tend to feel that I'm a failure ☐
- 9) I take a positive attitude toward myself ☐

## Part 8: Self-efficacy

### 1. To what extent are the following statements true?

1=Not at all true 2=Not really true 3=Nearly true 4= Exactly true

- 1) I can always manage to solve difficult problems if I try hard enough ☐
- 2) If someone opposes me, I can find the means and ways to get what I want ☐
- 3) It is easy for me to stick to my aims and accomplish my goals ☐
- 4) I am confident that I could deal efficiently with unexpected events ☐
- 5) Thanks to my resourcefulness, I know how to handle unforeseen situations ☐
- 6) I can solve most problems if I invest the necessary effort ☐
- 7) I can remain calm when facing difficulties because I can rely on my coping abilities ☐
- 8) When I am confronted with a problem, I can usually find several solutions ☐
- 9) If I am in trouble, I can usually think of a solution ☐
- 10) I can usually handle whatever comes my way ☐
  
- 11) I am certain that I know how to recognise the symptoms of has malaria without asking somebody else ☐
- 12) I am certain that I know where to go if I have malaria without asking somebody else ☐
- 13) I am certain that I know what medicine to take for malaria without asking somebody else ☐
- 14) I trust my child to go see a health professional by themselves when they have malaria without asking me first ☐
- 15) I am certain that I know how to recognise the symptoms of fever without asking somebody else ☐
- 16) I am certain that I know where to go if I have fever without asking somebody else ☐
- 17) I am certain that I know what medicine to take for fever without asking somebody else ☐

- 18) I trust my child to go see a health professional by themselves when they have fever without asking me first [\_\_]
- 19) I feel confident talking to health professionals when I am sick [\_\_]
- 20) I feel health professionals take me seriously when I talk to them [\_\_]

## Appendix three

**Appendix three: Table showing comparison of changes in knowledge among young people before and after photovoice**

	Intervention			Control		
	Before <i>n</i> (%)	After <i>n</i> (%)	p-value	Before <i>n</i> (%)	After <i>n</i> (%)	p-value
<b>Causes of malaria</b>						
Sudden changes in weather	28 (57.1)	21 (50.0)	0.496	54 (84.4)	43 (72.9)	0.119
Fatigue	25 (51.0)	17 (40.5)	0.314	44 (68.8)	36 (61.0)	0.369
Hunger	24 (49.0)	14 (33.3)	0.131	50 (78.1)	39 (66.1)	0.136
Dirty food	31 (63.3)	21 (50.0)	0.202	54 (84.4)	50 (84.7)	0.955
coconut water	5 (10.2)	8 (19.0)	0.229	17 (26.6)	17 (28.7)	0.780
Dirty water	30 (61.2)	26 (61.9)	0.947	49 (76.6)	50 (84.7)	0.253
Dirty surroundings	42 (85.7)	39 (92.9)	0.277	56 (87.5)	55 (93.2)	0.285
Mosquitoes	47 (97.9)	40 (45.2)	0.480	62 (98.4)	57 (96.6)	0.521
<b>Symptoms of malaria</b>						
Headache	<b>41 (83.7)</b>	<b>24 (57.1)</b>	<b>0.005*</b>	59 (92.2)	54 (91.5)	0.893
Fever	36 (73.5)	29 (69.0)	0.642	59 (92.2)	54 (91.5)	0.893
Chilling	37 (75.5)	38 (90.5)	0.062	58 (90.6)	51 (86.4)	0.465
Body pain	29 (59.2)	23 (54.8)	0.671	54 (84.4)	44 (74.6)	0.177
Sweating	29 (59.2)	24 (57.1)	0.844	<b>53 (82.8)</b>	<b>39 (66.1)</b>	<b>0.033*</b>
Loss of appetite	37 (75.5)	25 (59.5)	0.103	55 (85.9)	46 (78.0)	0.249
Loss of energy	<b>40 (81.6)</b>	<b>24 (57.1)</b>	<b>0.011*</b>	59 (92.2)	51 (86.4)	0.300
Dizziness	40 (81.6)	28 (66.7)	0.101	56 (87.5)	47 (79.7)	0.239
Coughing	<b>38 (77.6)</b>	<b>20 (47.6)</b>	<b>0.003*</b>	<b>58 (90.6)</b>	<b>42 (71.2)</b>	<b>0.006*</b>
Vomiting	35 (71.4)	22 (52.4)	0.061	51 (79.7)	39 (66.1)	0.089
Diarrhoea	25 (51.0)	14 (33.3)	0.089	<b>46 (71.9)</b>	<b>30 (50.8)</b>	<b>0.016*</b>
Diarrhoea and vomiting	20 (40.8)	16 (38.1)	0.791	<b>42 (65.6)</b>	<b>28 (47.5)</b>	<b>0.042*</b>

<b>Knowledge of allopathic medicines for malaria</b>						
Listed at least one correct medicine for malaria	4 (8.2)	3 (7.1)	0.855	4 (6.3)	3 (5.1)	0.780
Listed at least one incorrect medicine for malaria	21 (42.9)	17 (40.5)	0.818	30 (46.9)	29 (49.2)	0.801

## Appendix four

**Appendix four: Table showing comparison of changes in malaria practices among young people before and after photovoice**

	Intervention			control		
	Before <i>n</i> (%)	After <i>n</i> (%)	p-value	Before <i>n</i> (%)	After <i>n</i> (%)	p-value
<b>Prevention practices</b>						
Clean the surroundings	48 (98.0)	41 (97.6)	0.912	63 (98.4)	56 (94.9)	0.271
Burn leaves for smoke	49 (100.0)	42 (100.0)	n/a	61 (95.3)	55 (93.2)	0.617
Spray the house	46 (93.9)	41 (97.6)	0.385	62 (96.9)	57 (96.6)	0.934
Cut plants	44 (89.8)	41 (97.6)	0.134	55 (85.9)	49 (83.1)	0.658
Keep animals close to the house	20 (40.8)	14 (33.3)	0.462	22 (34.4)	17 (28.8)	0.508
Drain stagnant water	<b>29 (59.2)</b>	<b>33 (78.6)</b>	<b>0.048*</b>	34 (53.1)	(27 (45.8)	0.415
Wear long sleeves	41 (83.7)	34 (81.0)	0.734	55 (85.9)	48 (81.4)	0.491
Use repellents	16 (32.7)	20 (47.6)	0.146	<b>7 (10.9)</b>	<b>31 (52.5)</b>	<b>0.000*</b>
Slap mosquitoes off the skin	47 (95.9)	42 (100.0)	0.186	63 (98.4)	57 (96.6)	0.512
Use electric mosquito killer	2 (4.1)	2 (4.8)	0.875	2 (3.1)	7 (11.9)	0.063
Avoid staying out after dark	35 (71.4)	36 (85.7)	0.101	<b>49 (76.6)</b>	<b>54 (91.5)</b>	<b>0.025*</b>
Burn coils	18 (36.7)	12 (33.3)	0.735	12 (18.8)	20 (33.9)	0.056
<b>Net possession and use</b>						
Possession of a net	49 (100.0)	42 (100.0)	n/a	64 (100.0)	59 (100.0)	n/a
Everyone in house sleeps under a net	41 (83.7)	38 (90.5)	0.339	<b>64 (100.0)</b>	<b>54 (91.5)</b>	<b>0.017*</b>

Slept under a net the previous night	46 (93.9)	38 (90.5)	0.544	<b>63 (98.4)</b>	<b>53 (89.8)</b>	<b>0.040*</b>
Net have holes	16 (32.7)	14 (33.3)	0.945	23 (35.9)	19 (33.3)	0.764
Fixes holes in net	45 (91.8)	41 (100.0)	0.061	60 (93.8)	55 (93.2)	0.905
Use of net for fishing	0 (0.0)	1 (2.4)	0.274	<b>0 (0.0)</b>	<b>5 (8.5)</b>	<b>0.017*</b>
Use of net for keeping animals	0 (0.0)	2 (4.8)	0.122	0 (0.0)	2 (3.4)	0.138
<b>Hypothetical first action</b>						
Go to the Barangay Health Centre	3 (6.1)	0 (0.0)	0.103	<b>0 (0.0)</b>	<b>4 (6.8)</b>	<b>0.034*</b>
Go the Rural Health Centre	<b>24 (49.0)</b>	<b>9 (21.4)</b>	<b>0.006*</b>	<b>25 (39.1)</b>	<b>6 (10.2)</b>	<b>0.000*</b>
Go to the Barangay Health Worker	0 (0.0)	0 (0.0)	n/a	1 (1.6)	1 (1.7)	0.944
Go to the hospital	0 (0.0)	0 (0.0)	n/a	1 (1.6)	1 (1.7)	0.954
Go to the traditional healer	1 (2.0)	0 (0.0)	0.352	2 (3.1)	2 (3.4)	0.934
Take herbal medicine	4 (8.2)	2 (4.8)	0.515	4 (6.3)	4 (6.8)	0.905
Cool the body with towels	0 (0.0)	0 (0.0)	n/a	0 (0.0)	0 (0.0)	n/a
Take Paracetamol/Biogesic	6 (12.2)	2 (4.8)	n/a	15 (23.4)	10 (16.9)	0.372
Take an anti-malarial	1 (2.0)	0 (0.0)	0.352	1 (1.6)	1 (1.7)	0.954
Take Bioflu/Nusip	0 (0.0)	0 (0.0)	n/a	1 (1.60)	0 (0.0)	0.335
Other	1 (2.0)	0 (0.0)	0.352	2 (3.1)	0 (0.0)	0.171
Nothing	0 (0.0)	0 (0.0)	n/a	4 (6.3)	0 (0.0)	0.51
Tell an adult first	<b>9 (18.4)</b>	<b>29 (69.0)</b>	<b>0.000*</b>	<b>5 (7.8)</b>	<b>29 (49.2)</b>	<b>0.000*</b>
<b>Actual first action</b>						
Go to the Barangay Health Centre	0 (0.0)	0 (0.0)	n/a	2 (6.3)	2 (9.1)	0.695
Go the Rural Health	4 (50.0)	5 (50.0)	1.000	10 (31.3)	2 (9.1)	0.054

Centre						
Go to the Barangay Health Worker	0 (0.0)	0 (0.0)	n/a	2 (6.3)	0 (0.0)	0.232
Go to the hospital	0 (0.0)	0 (0.0)	n/a	0 (0.0)	0 (0.0)	n/a
Go to the traditional healer	0 (0.0)	0 (0.0)	n/a	2 (6.3)	1 (4.5)	0.788
Take herbal medicine	1 (12.5)	0 (0.0)	0.302	1 (3.1)	3 (13.6)	0.147
Cool the body with towels	0 (0.0)	0 (0.0)	n/a	0 (0.0)	0 (0.0)	n/a
Take Paracetamol/Biogesic	2 (25.0)	0 (0.0)	0.131	11 (34.4)	3 (13.6)	0.088
Take an anti-malarial	0 (0.0)	0 (0.0)	n/a	0 (0.0)	1 (4.5)	0.223
Take Bioflu/Nusip	0 (0.0)	0 (0.0)	n/a	0 (0.0)	0 (0.0)	n/a
Other	0 (0.0)	0 (0.0)	n/a	0 (0.0)	0 (0.0)	n/a
Nothing	0 (0.0)	0 (0.0)	n/a	0 (0.0)	0 (0.0)	n/a
Tell an adult first	1 (12.5)	3 (37.5)	0.248	<b>4 (12.5)</b>	<b>10 (45.5)</b>	<b>0.007*</b>

## Appendix five

**Appendix five: DVD (enclosed on back cover) with two films produced by young people as an output from photovoice.**



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